



Presbyterian Insurance Company, Inc.

Summary Plan Description and Guide to Your Preferred
Provider Organization (PPO) Plan

Group Metal Benefit Plans
LF PPO TytoHome

Offered by your Employer Group Administered by Presbyterian Health Plan
Underwritten by Presbyterian Insurance Company, Inc.

PIC_SGLF_PPO__TytoHome_2024

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01/01/2024-12/31/2024

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

Address:

Presbyterian Insurance Company, Inc.
Attention: Presbyterian Customer Service Center
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone:

(505) 923-6980 or
1-800-923-6980
TTY 711

Prior Authorization

Address:

Presbyterian Insurance Company, Inc.
Attention: Health Services Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone:

(505) 923-8469 or
1-866-597-7835

Claims

Address:

Presbyterian Insurance Company, Inc.
Attention: Claims Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone:

(505) 923-6980 or
1-800-923-6980

Appeals and Grievances

Address:

Presbyterian Insurance Company, Inc.
Attention: Grievance Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone:

(505) 923-5644 or
1-800-923-6980

Fax:

(505) 923-6111

OR

Address:

Office of Superintendent of Insurance
Managed Health Care Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689

Phone:

(505) 827-4601 or
1-855-427-5674

Fax:

(505) 827-4253

Website

www.phs.org

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Welcome

Welcome to Presbyterian Insurance Company!

Welcome and thank you for enrolling in a Presbyterian Insurance Company, Inc. Preferred Provider Organization (PPO) Plan. We are a Healthcare Insurer operated as a division of Presbyterian Healthcare Services, a locally owned New Mexico healthcare system. When we use the words "Presbyterian Insurance Company", "PIC", "we", "us", and "our" in this document, we are referring to Presbyterian Insurance Company, Inc. When we use the words "you" and "your," we are referring to each Member.

We are pleased to provide you with access to a comprehensive network of physicians, Hospitals, and outpatient medical providers, who provide services for Covered Benefits received both In-network and Out-of-network. We also provide utilization management and quality improvement oversight programs. We work closely with you, your Covered Dependents and your healthcare Practitioners and Providers to provide choice and flexibility in a quality, affordable healthcare plan.

As an additional benefit PIC contracts with National Network, a national preferred Provider organization with over 3,500 acute care Hospitals and 400,000 Providers. If you live or are traveling outside the State of New Mexico, and require medical attention, we encourage you to see National Network Providers and Facilities. National Network Providers provide care to PIC Members at discounted rates, which help keep the cost of Medical Care down. Additionally, you cannot be charged for any difference between what PIC pays the Provider and what the Provider charges beyond your appropriate Copayment and/or Deductible and Coinsurance.

Our Plan with You

This is your Summary Plan Description (Plan), and it is a legal document. This Plan along with the *Summary of Benefits and Coverage*, describes the Covered Healthcare Benefits and plan features that you and your eligible Dependents may receive when you enroll.

This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Information you will find in this Plan includes:

- Your rights and responsibilities as a Member
- Covered Benefits available through this Plan
- How to access services from physicians, Practitioners, Providers, and Pharmacies
- Services that require **Prior Authorization**
- **Limitations and Exclusions** for certain Covered Benefits

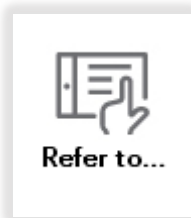
- Coverage for your Dependents who are outside of New Mexico
- A Glossary of Terms used in this Plan
- What to do when you need assistance

Throughout this Plan, we ask you to refer to your *Summary of Benefits and Coverage*. The *Summary of Benefits and Coverage* is a chart that shows some specific Covered Benefits this Plan provides, the amount you may have to pay (Cost Sharing) and the Coverage **Limitations and Exclusions**.

Please take time to read this Plan and *Summary of Benefits and Coverage*, including Benefits, **Limitations, and Exclusions**. Understanding how this Plan works can help you make the best use of your Covered Benefits. You should keep this Plan, your *Summary of Benefits and Coverage*, and any other attachments or Endorsements you may receive for future reference.

Understanding This Plan

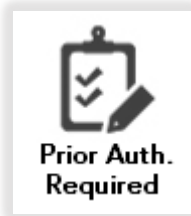
We use visual symbols throughout this Plan to alert you to important requirements, restrictions and information. When one or more of the symbols is used, we will use bold print in the paragraph or section to point out the exact requirement, restriction, and information. These symbols are listed below:



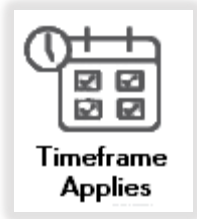
Refer To – This “Refer To” symbol will direct you to read related information in other sections of the Plan or *Summary of Benefits and Coverage* when necessary. The Section being referenced will be bolded.



Exclusion – This “Exclusion” symbol will appear next to the description of certain Covered Benefits. The Exclusion symbol will alert you that there are some services that are excluded from the Covered Benefits and will not be paid. You should refer to the Exclusion Section when you see this symbol.



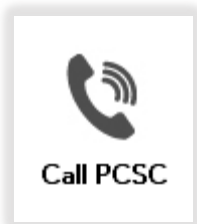
Prior Authorization Required – This “Prior Authorization” symbol will appear next to those Covered Benefits that require our Authorization (approval) in advance of those services. To receive full benefits, your In-network Practitioner/Provider must call us and obtain Authorization before you receive treatment. You must call us if you are seeking services Out-of-network. In the case of a Hospital in-patient admission following an Emergency Room visit, you or your physician should call as soon as possible.



Timeframe Requirement – This “Timeframe” symbol appears to remind you when you must take action within a certain timeframe to comply with your Plan. An example of a Timeframe Requirement is when you must enroll your newborn within **31 days** of birth.



Important Information – This “Important Information” symbol appears when there are special instructions or important information about your Covered Benefits or your Plan that requires special attention. An example of Important Information would be if there are no Covered Benefits when you receive care Out-of-network.



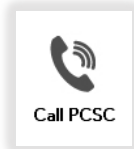
Call Presbyterian Customer Service Center – This “Call PCSC” symbol appears whenever we refer to our local Presbyterian Customer Service Center or to remind you to call us for information.

In addition, some important terms used throughout this Plan and the *Summary of Benefits and Coverage* will be capitalized. These terms are defined in the Glossary of Terms Section.

Customer Assistance

Presbyterian Customer Service Center (PCSC)

If you have any questions about your Health Benefit Plan, please call our Presbyterian Customer Service Center. We have Spanish- and Navajo-speaking representatives, and we offer translation services for more than 140 languages.



Our local Presbyterian Customer Service Center representatives are available Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711**. You may visit our website for useful health information and services at www.phs.org.

Consumer Assistance Coordinator

If you need assistance completing any of our forms, if you have special needs, or if you need assistance in protecting your rights as a Member, please call our Consumer Assistance Coordinator at **(505) 923-5644** or **1-800-923-6980**. Hearing impaired users may call **TTY 711** or visit our website at www.phs.org.

Written Correspondence

You may write to us about any question or concern at the following address:

Presbyterian Insurance Company, Inc.
Attention: Presbyterian Customer Service Center
P.O. Box 26267
Albuquerque, NM 87125-6267

Member Rights and Responsibilities

This Section explains your rights and responsibilities under this Plan and how you can participate on our Consumer Advisory Board.

As a Member of Presbyterian Insurance Company (PIC), you have specific rights and certain responsibilities.

In accordance with New Mexico Administrative Code, we implement written policies and procedures regarding the rights and responsibilities of Covered Persons and implementation of such rights and responsibilities. Your rights and responsibilities are important and are explained in this Section and on our website at <https://www.phs.org/member-rights>.

Member Rights

The Summary Plan Description (Plan) shall include a complete statement that a Member shall have the right to:

- Available and accessible services when medically necessary, **24 hours** per day, **seven days** per week for Urgent or Emergency Healthcare Services, and for other Healthcare Services as defined by the SPD;
- A right to be treated with respect and recognition of their dignity and their right to privacy;
- Be provided with information concerning our policies and procedures regarding products, services, Providers, Appeals procedures and other information about Presbyterian Insurance Company and the benefits provided;
- To choose a Primary Care Practitioner within the limits of the Covered Benefits, plan network, and as provided by this rule, including the right to refuse care of specific Healthcare Professionals;
- Receive from the Covered Person's Physician(s) or Provider, in terms that the Covered Person understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of our position on treatment options; if the Covered Person is not capable of understanding the information, the explanation shall be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the Covered Person's medical record;
- All the rights afforded by law, rule, or regulation as a patient in a licensed Healthcare Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Covered Person understands;
- Prompt notification, as required in this rule, of termination or changes in benefits, services or Provider network;
- File a Complaint or Appeal with us or the Superintendent and to receive an answer to those Complaints in accordance with existing law;

- Privacy of medical and financial records maintained by us and our Healthcare Providers, in accordance with existing law;
- Know upon request of any financial arrangements or provisions between Presbyterian Insurance Company and our Providers which may restrict referral or treatment options or limit the services offered to Covered Persons;
- Adequate access to qualified Health Professionals for the treatment of Covered Benefits near where the Covered Person lives or works within our Service Area;
- To the extent available and applicable to us, to affordable healthcare, with limits on Out-of-pocket expenses, including the right to seek care from a non-participating (Out-of-network) Provider, and an explanation of a Covered Person’s financial responsibility when services are provided by a non-participating (Out-of-network) Provider, or provided without required **Prior Authorization**;
- An approved example of the financial responsibility incurred by a Covered Person when going Out-of-network; inclusion of the entire “billing examples” provided by the Superintendent available on the Division’s website at the time of the filing of the plan will be deemed satisfaction of this requirement; any substitution for, or changes to, the Division’s “billing examples” requires written approval by the Superintendent, in our Healthcare Benefit Plan that provides benefits for Out-of-network Coverage;
- Detailed information about Coverage, Maximum Benefits, and Exclusions of specific conditions, ailments or disorders, including restricted Prescription benefits, and all requirements that a Covered Person must follow for **Prior Authorization** and Utilization Review;
- A complete explanation of why care is denied, an opportunity to Appeal the decision to our internal review, the right to a secondary Appeal, and the right to request the Superintendent’s assistance.

Additional Member Rights and Responsibilities

In addition to the rights and responsibilities afforded you by the state, we provide our Members with the following additional rights to:

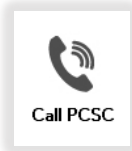
- Receive information about our organization, our services and benefits, how to access Healthcare Services, our Practitioners and Providers, and your rights and responsibilities;
- Have a clear, private and candid discussion about appropriate or Medically Necessary treatment options for your medical condition regardless of cost or benefit Coverage;
- Participate with your Practitioner/Provider in making decisions about your healthcare;
- Refuse care, treatment, medication or a specific Practitioner/Provider, after the consequences of your decision have been explained in a language that you understand;
- Seek a second opinion for surgery from another In-network Practitioner/Provider when you need additional information regarding recommended treatment or requested care;
- Receive Healthcare Services in a non-discriminatory fashion. This means that you may not be denied Covered Services on the basis of race, color, sex, sexual preference, age, disability, cultural or educational background, religion or national origin, economic or health status or source of payment for care. If you have a disability, you have the right to

receive any information in an alternative format in compliance with the Americans with Disabilities Act;

- Make recommendations regarding our Members' rights and responsibilities policies;
- Make your wishes known through an Advance Directive regarding healthcare decisions, such as living wills or right-to-die directives, consistent with federal and state laws and regulations;
- Choose a surrogate decision maker to assist with care decisions. If you are unable to understand your medical care, to have the healthcare explanation provided to the next of kin, guardian, agent or surrogate if available, and recorded in your medical record including, where appropriate, a medical release that you signed authorizing release of medical information.

You and or your legal guardian/representative have the responsibility to:

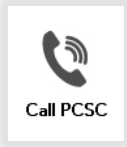
- Provide, whenever possible, the information that we and your Practitioners/Providers need in order to provide services or care and to oversee the quality of those services or care;
- Follow the plans and instructions for care that you have agreed upon with your treating Practitioner/Provider. You may, for personal reasons, refuse to accept treatment recommended by Practitioners/Providers. Practitioners/Providers may regard such refusal as incompatible with continuing the Practitioner/Provider-patient relationship and as obstructing the provision of proper medical care;
- Understand your health problems and to participate in developing mutually agreed upon treatment plans and goals;
- Review your Summary Plan Description (Plan) and if you have questions, contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711**. You may visit our website at www.phs.org for clarification of Benefits, Limitations, and Exclusions outlined in this Subscriber Plan. Translation/Interpretation services to understand your benefits are available, please call our Customer Service Center at the phone numbers listed above;
- Notify us within **31 days** of any changes of name, address, telephone number, marital status, eligible Dependents or newborns;
- Immediately notify us or any loss or theft of your PIC Identification Card;
- Refuse to allow any other person to use your PIC Identification Card;
- Advise a Practitioner/Provider of your Coverage with us at the time of service. You may be required to pay for services if you do not inform your Practitioner/Provider of our Coverage;
- Pay all required, pre-determined Cost Sharing (Deductible, Coinsurance, Copayments) at the time services are rendered when amounts due are made clear at that time;
- Pay for all services obtained prior to the effective date of this Plan and subsequent to its termination or cancellation;
- Ensure that all information you give to us in Applications for enrollment, questionnaires, forms or correspondence is true and complete;



- Be informed of the potential consequences of providing us with incorrect or incomplete information as described in this Plan;
- Obtain **Prior Authorization** as described in the **Prior Authorization** Section;
- Pay any charges over Medicare Allowable.

Consumer Advisory Board

We have established a Consumer Advisory Board and we want your participation. This Board meets quarterly and provides Members' perspectives, as healthcare consumers, on the products and services that we offer. In addition, we share information with the Consumer Advisory Board on how well the health plan is performing. The information we receive is very valuable and helps us improve the health of individuals, families and communities. If you are interested in serving on our Consumer Advisory Board, please call our Presbyterian Customer Service Center, Monday through Friday 7 a.m. to 6 p.m., at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711**. You may also visit our website at www.phs.org.



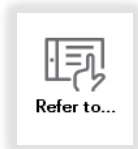
How the Plan Works

This Section explains how to find Practitioners/Providers who are in our network (In-network), get Healthcare Services both In-network and Out-of-network, requirements you must follow when getting care and how to receive Covered Benefits under this Plan.

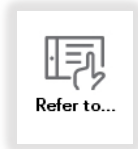
This plan is a Preferred Provider Organization (PPO) Healthcare Plan. Each time you need Healthcare Services, you can choose your Practitioners and Providers and the level of Covered Benefits that will apply to their charges. You will receive the highest level of Covered Benefits and the lowest cost to you when you obtain services from our In-network Practitioners/Providers. You still have the flexibility provided by the Out-of-network benefits to see any Practitioner/Provider you choose for many of your Healthcare Services.

Presbyterian Insurance Company accepts premium and Cost-Sharing payments from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or Cost-Sharing): a Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act, an Indian tribe, tribal organization, or urban Indian organization, and a local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

In-network Benefits

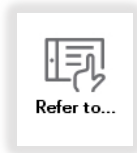


In order to be eligible to enroll and participate in this Plan you must work for an employer Group that is headquartered in the State of New Mexico (our Service Area). Your Dependents may be eligible to enroll if they meet all of the terms and conditions for such Coverage as described in the **Eligibility, Enrollment and Effective Dates, Termination and Continuation of Coverage Section.**



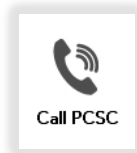
When you or your Covered Dependents receive care from Practitioners and Providers in our network (In-network Practitioners/Providers), the In-network benefit level will apply to the cost of the Healthcare Services. You will be responsible for your Cost-Sharing amounts (Copayments, Deductibles or Coinsurance) at the time of service. As shown in your *Summary of Benefits and Coverage*, your benefit levels are highest, and your Out-of-pocket Cost-Sharing amounts are lowest when you use our In-network Practitioner/Providers.

Your In-network Practitioner/Provider will bill us directly for the cost of services. You will generally not have claims to file or papers to fill out in order to be reimbursed for medical services obtained from In-network Practitioners and Providers. In-network Practitioners and Providers cannot bill you for any additional costs over and above your Cost-Sharing amounts.



Hospital Inpatient Admission and some other Healthcare Services require our review and **Prior Authorization** before the services are provided. If you seek care from an In-network Practitioner/Provider, your In-network Practitioner/Provider will notify us and handle all aspects of your care. Please refer to the **Prior Authorization Section** for complete details on **Prior Authorization**.

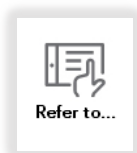
Provider Directory



You will find our In-network Practitioners/Providers close to where you live and work across the State. Our Provider Directory lists the In-network Practitioners, as well as In-network Hospitals, pharmacies, outpatient facilities and other healthcare Providers. The Provider Directory is available on our website at https://www2.phs.org/providers?insurance_plans=group-ppo.

If you need additional information about a Provider or would like to report an inaccuracy in the Provider Directory, you may call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711**. Additionally, you may submit a Provider Directory inaccuracy report online at www.phs.org/providers and by navigating to the identified Provider's detail page and choosing the *Report Inaccuracies* option.

The Provider Directory is subject to change, and you should always verify the Practitioner's/Provider's network status by visiting our website at https://www2.phs.org/providers?insurance_plans=group-ppo. Updates are made to the Provider Directory on a daily basis, so the online version is always the most current list. However, if you require a printed copy of the directory, you may request it by calling the Presbyterian Customer Service Center at the number above.



If our Provider Directory lists inaccurate information that you relied on in choosing a Provider, you will only be responsible for paying your In-network Cost-sharing amount for care received from that Provider. Please refer to the **Summary of Health Insurance Grievance Produces Section** to understand your rights for filing an appeal.

Out-of-Network Care and Bills

If you receive care under any of the circumstances below from a Provider who is not in your network, these are your rights:

If you receive emergency care out-of-network, including air ambulance service:

- You are only responsible for paying what you would owe for the same care from an In-network Provider or facility.
- You do NOT need to get **Prior Authorization** for emergency services.
- Your care can continue until your condition has stabilized. If you require additional care after stabilization, call us at **1-866-597-7835** and we will help you receive that care from

- an In-network Provider.
- You cannot be balance billed.

If you receive care from an Out-of-network Provider at an in-network facility, such as a Hospital that is in your plan, you are only responsible for paying what you would owe for the same care from an In-network Provider if any of the following apply:

- You did not consent to services from an Out-of-network Provider.
- You were not offered the service from an In-network Provider.
- The service was not available from an In-network Provider as determined by your healthcare Provider and your health insurance company.

If you get a bill from an Out-of-network Provider under any of the above circumstances that you do not believe is owed:

- Call us first at **(505) 923-6980**. We will try to resolve the issue with the Provider on your behalf.

To help stop improper out-of-network bills, we will:

- Notify you if your Provider leaves our network and allow you transitional care with that Provider at the In-network benefit level for up to **90 days** depending on your condition and course of treatment.
- Verify the accuracy of our Provider directory information at least every **90 days**.
- Confirm whether a Provider is In-network if you contact us at **(505) 923-6980**. If our representative provides inaccurate information that you rely on in choosing a Provider, you will only be responsible for paying your In-network Cost-Sharing amount for care received from that Provider.

You have the right to receive notice of the following before you receive Out-of-network care at an In-network facility:

- A “good faith estimate” of the charges for Out-of-network care.
- At least **five days** to change your mind before you receive a scheduled Out-of-network service. If you choose to receive Out-of-network care, you will be responsible for Out-of-network charges that we do not cover.
- A list of In-network Providers and the option to be referred to any such Provider who can provide necessary care.

If you pay an Out-of-network Provider more than we determine you owe:

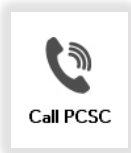
- The Provider will owe you a refund within **45 days** of receipt of payment by us.
- If you do not receive a refund within that **45-day** period, the Provider will owe you the refund plus interest.

National PPO Providers

As an additional benefit PIC contracts with National Network, a national preferred Provider As an additional benefit PIC contracts with a national network of preferred providers through Aetna Signature Administrators® a robust network of healthcare professionals including primary care, specialist, and hospitals. If you live or are traveling outside the State of New Mexico, and require medical attention, we encourage you to see one of these providers or facilities.



These Practitioners/Providers **are not responsible** for obtaining **Prior Authorization** (if required). You must obtain **Prior Authorization** (if required) for services provided by a National Network Provider and follow all other rules regarding Out-of-network Practitioners/Providers.



For additional information or to see if you need a **Prior Authorization** for Out-of-network Services, their provider directory is available through their website at <https://www.aetna.com/asa> or you can call our local Presbyterian Customer Service Center prior to obtaining services Monday through Friday from 7 a.m. to 6 p.m. at (505) 923-6980 or 1-800-923-6980. Hearing impaired users may call TTY

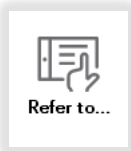
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Cost-Sharing – Your Out-of-pocket Costs

Many Healthcare Services you receive from In-network and Out-of-network Practitioners and Providers require some payment from you. We refer to these payments as Cost Sharing. These are your Out-of-pocket costs and may be Deductibles, Coinsurance and/or Copayment amounts. Cost Sharing and benefits for an emergency healthcare service rendered by a non-participating provider shall be the same as if rendered by a participating provider. Cost Sharing and benefit limitations for medically necessary, non-emergent healthcare services rendered by a non-participating provider at a participating facility where the covered person had no ability or opportunity to choose to receive the service from a participating provider or where no participating provider is available to render the service shall be the same as if the service was rendered by a participating provider.

Annual Contract Year Deductible

Certain services are subject to an Annual Contract Year Deductible. The Annual Contract Year Deductible is the amount you and your Covered Dependents must pay for Covered Healthcare Services each Contract Year before we begin to pay Covered Benefits for that Member. The Annual Contract Year Deductible may not apply to all Healthcare Services. You will pay a lower Annual Contract Year Deductible amount when you visit In-network Practitioners/Providers. Refer to **What is the overall deductible?** in your *Summary of Benefits and Coverage* for the amount of your Annual Contract Year Deductible.



Covered charges for In-network Practitioner and Provider services only apply to the In-network Annual Contract Year Deductible limits and do not apply to the Out-of-network Annual Contract Year Deductible limits shown in the *Summary of Benefits and Coverage*.

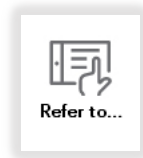
Covered charges for Out-of-network Practitioner and Provider services only apply to the Out-of-network Annual Contract Year Deductible limits and do not apply to the In-network Annual Contract Year Deductible limits shown in the *Summary of Benefits and Coverage*.

For Single coverage, the annual Contract Year Deductible requirement is fulfilled when one Member meets the individual Deductible listed in the *Summary of Benefits and Coverage*.

For double or family coverage, with two or more enrolled Members, the **entire** Family the annual Contract Year Deductible must be met before benefits will be paid for the family. However, if one (family) Member reaches the Individual Deductible amount before the Family has met the annual Contract Year Family Deductible, the Plan will begin paying benefits for that Member who has met the Individual Deductible. The annual Contract Year Family and Individual Deductible amounts are listed in the *Summary of Benefits and Coverage*.

Coinsurance

Certain services are subject to a Coinsurance amount. Coinsurance is the percentage of Covered charges that you and your Covered Dependents must pay directly to the Practitioner/Provider for



Covered Services after the Annual Contract Year Deductible has been met. After you pay your Coinsurance amount, we will pay our percentage of the charges. Coinsurance is included in your Annual Out-of-pocket Maximum. The amount of your Coinsurance for each service can be found in your *Summary of Benefits and Coverage*.

You will pay a lower percentage (Coinsurance) of Covered charges when you visit our In-network Practitioners/Providers. When you receive services from Out-of-network Practitioners/Providers, the Coinsurance you pay is higher and the Coinsurance will be applied to Medicare Allowable or billed charges, whichever is less, that we allow or the particular procedure. The Out-of-network Practitioner/Provider may bill you for any amounts over the billed charges we allow, and this amount does not apply to your Annual Contract Year Deductible or your Coinsurance.

Covered charges for In-network Practitioner and Provider services only apply to the In-network Coinsurance limits and do not apply to the Out-of-network Coinsurance limits shown in the *Summary of Benefits and Coverage*.

Covered charges for Out-of-network Practitioner and Provider services only apply to the Out-of-network Coinsurance limits and do not apply to the In-network Coinsurance limits shown in the *Summary of Benefits and Coverage*.

Refer to your *Summary of Benefits and Coverage* for the Coinsurance Amounts. Coinsurance Amounts vary by type of service and by In-network and Out-of-network Practitioners/Providers.

Annual Out-of-pocket Maximum



This Plan includes an Annual Out-of-pocket Maximum amount to help protect you and your Covered Dependents from high-cost catastrophic healthcare expenses. The Annual Out-of-pocket Maximum is the most you will pay in Cost Sharing in a Contract Year for certain Covered Services. After you have met your Annual Out-of-pocket Maximum in a Contract Year, we pay 100 percent (100%) of the cost for Covered Services, for the remainder of that Contract Year, up to the maximum

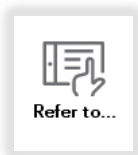
benefit amount, if any. Refer to **What is the Out-of-pocket limit for this Plan?** in your *Summary of Benefits and Coverage* for the Plan Annual Out-of-pocket Maximum.

For single coverage, the Out-of-pocket Maximum requirement is fulfilled when one Member meets the Individual Out-of-pocket Maximum listed in the *Summary of Benefits and Coverage*.

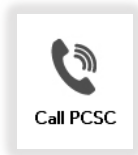
For double or family coverage, with two or more enrolled Members, the entire Family Out-of-pocket Maximum must be met before benefits will be paid at 100 percent (100%). However, if one (family) Member reaches the Individual Out-of-pocket maximum amount before the Family has met the Family Out-of-pocket maximum benefits will be paid at 100 percent (100%) for that Member who has met the Individual Out-of-pocket maximum. The Family and Individual Out-of-pocket maximums amounts are listed in the *Summary of Benefits and Coverage*.

You will pay less out of your pocket (Cost Sharing) to meet your Annual Out-of-pocket Maximum when you visit an In-network Practitioner/Provider.

Covered charges for In-network Practitioner and Provider services **only** apply to the In-network Coinsurance and Annual Out-of-pocket Maximum limits and do not apply to the Out-of-network Coinsurance and Annual Out-of-pocket Maximum shown on the *Summary of Benefits and Coverage*.



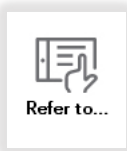
Covered charges for Out-of-network Practitioner and Provider services **only** apply to the Out-of-network Coinsurance and Annual Out-of-pocket Maximum limits and do not apply to the In-network Limits shown on the *Summary of Benefits and Coverage*. Refer to **What is the Out-of-pocket limit for this plan?** in your *Summary of Benefits and Coverage* for the Plan Annual Out-of-pocket Maximum.



To inquire about the status of your specific Annual Out-of-pocket Maximum, you may call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711**.

Office Visit Copayment

If your Plan has an Office Visit Copayment, this is the amount of Cost Sharing you must pay each time you have an office visit with an In-network Practitioner/Provider. This Copayment is for the office visit only. All other services provided during the visit are subject to other Cost Sharing (Deductible and Coinsurance). Refer to **If you visit a health care Provider's office or clinic** in your *Summary of Benefits and Coverage* for all Cost-Sharing Copayment, Deductible and Coinsurance amounts. Cost-sharing and benefit limitations for a medically necessary, non-emergent health care service where no participating provider is available to render the services shall be the same as if the service was rendered by a participating provider.



Specialist Care

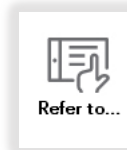
As our Member, you must carefully follow all procedures and conditions for obtaining care from In-network specialists and/or Out-of-network Practitioners/Providers. We no longer require a paper referral from your Primary Care Provider (PCP) for your visits to specialists. However, it is important to your healthcare that your PCP is included in the decisions about the specialists that you visit. Your PCP continues to be your partner for good health and is the best person to help you determine your needs for specialty care.

Effective communication about your medical history and treatment between your PCP and the specialists that provide care for you is very important so that the best decisions can be made about your medical care. We recommend that you contact your PCP's office regarding your desire to visit a specialist.

Please note that some specialists may require written referral even though we do not. Certain procedures require **Prior Authorization**. Your In-network Practitioner/Provider must obtain this **Prior Authorization** before providing these services to you. Please refer to the **Prior Authorization** Section of this Plan.

Obtaining Care after Normal Provider Office Hours

Most Providers offer an after-hours answering service. For non-emergency situations, you should phone your PCP. If needed, you can find your PCP's phone number in the Provider Directory. If Emergency Healthcare Services are needed, you should call 911, or seek treatment at an emergency room. If in need of Urgent Care, you may seek treatment at an Urgent Care Center that is available and open for business. Please note that some Urgent Care Centers are not open after 8 p.m. In such circumstances, it may be necessary to use an emergency room for care that is needed on an urgent basis. Please refer to the **Benefits Section, Accidental Injury (Trauma) / Urgent Care / Emergency Health Services / Observation** of this Plan for a detailed description of Coverage for Urgent and Emergency Healthcare Services.



Utilization Management and Quality

We may review medical records, claims, and requests for Covered Services to establish that the services are/were Medically Necessary, delivered in the appropriate setting, consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of our professional medical consultants. The review will also be in accordance with applicable, generally accepted principles and practices of good medical care, practice guidelines developed by the federal government or national or professional medical societies, boards or associations, or applicable clinical protocols or practice guidelines developed by the health insurer consistent with federal, national and professional practice guidelines, which shall apply to the diagnosis, direct care and treatment of a physical or behavioral health condition, illness, injury or disease pursuant to 59A-22B-2J NMSA.

Members may seek a second opinion when questions arise as to the medical appropriateness of a diagnosis or the appropriateness of medical and/or surgical services. Members may seek the second opinion from any provider In- or Out-of-network. Typical Cost-Sharing will apply.

Technology Assessment Committee

We have a process to continuously evaluate evolving medical technologies, which include medical procedures, drugs and devices. In-network Practitioners from our PPO Network and the community along with other clinical staff are responsible for this process and are known as the Technology Assessment Committee.

The Technology Assessment Committee evaluates new technologies and/or new applications of existing technologies, determines the value of the new technology, and recommends whether the technology should be a specified Covered Benefit of your Plan. Factors to be considered include safety, comparison to existing drugs, procedures and technology, cost and effectiveness of the new technology, and clinical skills and training of those proposing to provide the new technology.

Transition of Care

If we terminate or suspend any contract with an In-network Practitioner/Provider from which you are currently receiving care, we will notify you, in writing, within **30 days**. We will assist you in locating and transferring to another similarly qualified In-network Practitioner/Provider, if available, for continued In-network benefits. You may elect to continue to receive care from this Out-of-network Practitioner/Provider; however, we will only reimburse for such services in accordance with applicable Out-of-network benefit level, if any, and then subject to Medicare Allowable Charges except when you wish to continue an ongoing course of treatment with the provider for a transitional period. This period shall continue for a time that is sufficient to permit coordinated transition planning consistent with your condition and needs relating to the continuity of the case and will not be less than **30 days**. If you are in your third trimester of pregnancy at the time of the provider's disaffiliation, your transitional period will last through

the delivery and will allow for post-partum care. These transitional periods with your provider will not be allowed if the provider's disaffiliation was for reasons related to medical competence or professional behavior. For transitional periods exceeding **30 days**, continued care will be provided only if the provider agrees to accept reimbursement from Presbyterian at the rates applicable prior to the start of the transitional period as payment in full. Additionally, the provider must also agree to adhere to Presbyterian's quality assurance requirements, to provide necessary medical information related to such care, and to follow Presbyterian's policies and procedures, including but not limited to procedures regarding referrals, pre-authorization and treatment planning approved by Presbyterian.

Advance Directives

An Advance Directive is a legal document about your healthcare decisions. It is only used when you are unable to make your wishes known and includes information about the person you want to make healthcare decisions on your behalf as well as medical services you do and do not want. These are documents you complete in advance and can share with your provider or person who will speak on your behalf. Sharing your advance directives with your healthcare team helps make your wishes clear. You can create an Advance Directive at our website:

<https://www.phs.org/tools-resources/patient/advance-directive>.

Termination of Provider Status

When PIC terminates or suspends any contract with a participating provider, PIC will notify, in writing, affected covered persons who are current patients of or, where applicable, assigned to the provider, within 30 days. The notice to covered persons shall advise them of their right to continue receiving care from the provider as set forth in 13.10.23.13 NMAC. Current patients are covered persons who have a claim with Presbyterian Insurance Company, Inc., (PIC) related to the provider's services within the past year, or who have received a pre-authorization prior to termination to use the provider's services at a future time.

Presbyterian Insurance Company will assist such affected covered persons in locating and transferring to another similarly qualified provider. A covered person may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the covered person, if the covered person has not received comparable notice during this time from the provider.

Prior Authorization

This Section explains what Covered Healthcare Services require Prior Authorization before you receive these services and how to obtain Prior Authorization. You can obtain further information through your PCP or at our website at www.phs.org/prior-authorization. If you have questions about a Prior Authorization submitted by your PCP/Provider, please contact us Monday through Friday from 8 a.m. to 5 p.m. at (505) 923-8469 or 1-866-597-7835. Hearing impaired users may call TTY 711.

Before you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or other facility or before you receive certain Covered Healthcare Services and supplies, you must request and obtain approval, known as Authorization. All diabetes related services are provided in accordance with State law. For diabetes related services, please refer to the Diabetes Services Section. You may be responsible for the resulting charge ***except in cases of emergency***.

What is Prior Authorization?

Prior Authorization is a clinical evaluation process to determine if the requested Healthcare Service is Medically Necessary, a Covered Benefit, and if it is being delivered in the most appropriate healthcare setting. Our Medical Director or other clinical professional will review the requested Healthcare Service in consultation with your medical provider and if it meets our requirements for Coverage and Medical Necessity, it is Authorized or Certified (approved) before those services are provided.

The **Prior Authorization** process and requirements are regularly reviewed and updated based on various factors including evidence-based practice guidelines, medical trends, Practitioner/Provider participation, state and federal regulations, and our policies and procedures.

A **Prior Authorization** will specify the length of time for which the Authorization is valid, which in no event shall be for more than 24 months. You may revoke an Authorization at any time.

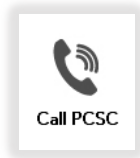
A consumer or customer who is the subject of nonpublic personal information may revoke an authorization provided pursuant to this rule at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

Prior Authorization when In-network

When you seek specific Covered Services from In-network Practitioners/Providers, our In-network Practitioner/Provider is responsible for obtaining **Prior Authorization** from us before providing the Covered Services. Prior Authorization is not required for Emergent or Urgent Care Services In- or Out-side of New Mexico. You will not be liable for charges resulting from the In-network Practitioner's/Provider's failure to obtain the required **Prior Authorization**.

Prior Authorization when Out-of-network

When you seek specific Covered Services from an Out-of-network Practitioner/Provider (including National Network Providers), **you** are responsible for obtaining **Prior Authorization** from us before receiving the Out-of-network Services. **If Prior Authorization (Certification) is not obtained when required, then we may not Cover the services and you may be responsible for the resulting charge.** You may have your Out-of-network Practitioner/Provider contact us on your behalf in order to provide necessary clinical information, but it is not the Out-of-network Practitioner's/Provider's responsibility to obtain **Prior Authorization**. Prior Authorization is not required for Emergent or Urgent Care Services In- or Out-side of New Mexico.

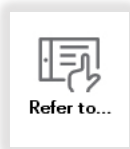


If you need to obtain **Prior Authorization** for Out-of-network Services, please call our Presbyterian Customer Service Center, as soon as possible before services are provided, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711**. You may also visit our website at www.phs.org.

Services That Require Prior Authorization In- or Out-of-Network

Prior Authorization is required for Inpatient admissions, and all services related to the inpatient admission before you receive these services In-network or Out-of-network from any Practitioner/Provider, Healthcare Facility or other Healthcare Professional. Our network of Practitioners/Providers will obtain **Prior Authorization** for you when you receive care In-network. You are responsible for obtaining **Prior Authorization** before you receive care Out-of-network. **Prior Authorization** is not required for Emergent or Urgent Care Services In- or Out-side of New Mexico. Presbyterian will provide material that contains in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility and **Prior Authorization** requirements, within a reasonable time after enrollment and at subsequent periodic times as appropriate.

Mental Health or Substance Use Disorder Hospital admissions, Inpatient non-emergent and Substance Use Disorder services, and Substance Use Disorder Inpatient services do not require prior authorization for the initial service.



The following services and supplies require **Prior Authorization** In-network and Out-of-network. Refer to the **Benefits Section** for detailed information about these services.

After inception of coverage, Presbyterian Insurance Company, Inc. (PIC) will not expand the list of benefits for which **Prior Authorization** is required except when a new covered benefit is added to the plan, when safety or other concerns have arisen with respect to the benefit, when authorized by a state or federal regulatory agency, or as indicated by changes in nationally recognized clinical guidance. After inception of coverage, PIC will notify its network providers

before adding a **Prior Authorization** requirement. PIC may remove a **Prior Authorization** requirement at any time. When PIC removes a **Prior Authorization** requirement during a plan year, PIC will notify its network providers of the change as soon as practicable, and no more than 60 days after the requirement is removed.

For a guide of services that require prior authorization, visit

https://onbasext.phs.org/PEL/DisplayDocument?ContentID=OB_000000002930.

- All Hospital Inpatient Admissions
- Autologous Chondrocyte Implantation (Carticel)
- Bariatric Surgery (Weight Loss Surgery)
- Blepharoplasty/Brow Ptosis Surgery
- Breast Reconstruction following Mastectomy
- Breast Reduction for Gynecomastia
- Chimeric Antigen Receptor T-cell Therapy
- Clinical Trial
- Computed Tomography (CT)
- Corneal Cross-linking
- CT Angiography (CTA)
- CV: Mobile Cardiac Outpatient Telemetry (MCOT) and Real-time Continuous Attended Cardiac Monitoring Systems
- Detoxification – Inpatient Acute requiring medical intervention (alcohol / substance)
- Durable Medical Equipment (DME)
- Dialysis
- ENT: Rhinoplasty
- ENT: Tonsillectomy or tonsillectomy with adenoidectomy
- ENT: Endoscopy Nasal/Sinus: Surgical (Balloon Dilation)
- Gastric Electric Stimulation for Treatment of Chronic Gastroparesis
- Gender Affirming Surgical Intervention
- Genetic Testing
- GI: Wireless Capsule Endoscopy
- Hip Resurfacing Total
- Hip Replacement Total
- Gyn: Hysterectomy
- Hypoglossal Nerve stimulation
- Home Health Services
- Hormone Pellet Insertion, Subcutaneous
- Hospice
- Hyperbaric Oxygen
- Knee, Arthroscopy
- Knee Replacement Total

- Lumbar/Cervical Spine Surgery
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Ortho: Ankle – Total Ankle Replacement Surgery (Arthroplasty)
- Ortho: Knee – Meniscus Implant and Allograft / Meniscus Transplant
- Orthotics
- Outpatient Observation
- Pain: Epidural Corticosteroid Injections for Back Pain
- Plastic surgery: Panniculectomy and Abdominoplasty and Body Contouring Procedures
- Plastic Surgery: Restorative / Reconstructive / Cosmetic Surgery and Treatment
- Positron Emission Tomography (PET)
- Prescription Drugs/Medications
 - (Please see the Presbyterian Health Insurance Exchange Metal Level *Formulary* list at <https://client.formularynavigator.com/Search.aspx?siteCode=0324498195>)
- Prosthetics
- Proton Beam Irradiation
- Respite
- Sacral Nerve Stimulation for Urinary and Fecal Incontinence
- Scans & Cardiac Imaging including Echocardiogram
- Selected Surgical/Diagnostic procedures
 - Blepharoplasty/Brow Ptosis Surgery
 - Breast Reconstruction following Mastectomy
 - Breast reduction for gynecomastia
 - Endoscopy Nasal/Sinus balloon dilation
 - Gender Confirmational Surgery
 - Hysterectomy
 - Lumbar/Cervical Spine Surgery
 - Major endoscopic procedures
 - Meniscus Implant and Allograft/Meniscus Transplant
 - Operative and cutting procedures
 - Panniculectomy
 - Preoperative and postoperative care
 - Rhinoplasty
 - Tonsillectomy
 - Total Ankle Replacement
 - Total Hip Replacement
 - Total Knee Replacement
 - Varicose Vein Procedures
- Skilled Nursing Facility (SNF) Services
- Skin Substitutes (Tissue-Engineered / Bioengineered)
- Sleep Studies (In a Facility)

- Transplants: Bone marrow/stem cell transplant: Allogeneic, Autologous
- Transplants: Heart (includes ventricular assist and artificial heart devices.)
- Transplants: Heart and Lung
- Transplants: Kidney
- Transplants: Liver
- Transplants: Lung and Lobar Lung
- Transplants: Pancreas and Kidney
- Transplants: Pancreas Islet Cell
- Transplants: Procurement, Transportation
- Transplants: Small Bowel, Small Bowel/Liver
- Veins: Varicose Vein Procedures including Echo sclerotherapy
- Virtual Colonoscopy
- Water Vapor Thermal Therapy for
- lower urinary tract symptoms (LUTS)/benign prostatic hyperplasia (BPH)
- X STOP® Interspinous Process Decompression

Prior Authorization Protocols

After January 1, 2014, a health care plan shall accept the uniform prior authorization form developed pursuant to Sections 2 [59A-2-9.8 NMSA 1978] and 3 [61-11-6.2 NMSA 1978] of this 2013 act as sufficient to request prior authorization for prescription drug benefits.

No later than twenty-four months after the adoption of national standards for electronic prior authorization, a health insurer shall exchange prior authorization requests with providers who have e-prescribing capability.

If a health care plan fails to use or accept the uniform prior authorization form or fails to respond within three business days upon receipt of a uniform prior authorization form, the prior authorization request shall be deemed to have been granted.

As used in this section, "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments but does not include:

- a person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;
- a physician or a physician group to which a health care plan has delegated financial risk for prescription drugs and that does not use a prior authorization process for prescription drugs; or
- a health care plan or its affiliated providers, if the health care plan owns and operates its pharmacies and does not use a prior authorization process.

Authorizing Inpatient Hospital Admission following an Emergency



You do not need to get **Prior Authorization** when you receive Emergency Healthcare Services. If you are admitted as an Inpatient to the Hospital following your Emergency Healthcare Services, your Practitioner/Provider or you should contact us as soon as possible.

- Eligibility and benefits are based on the date you received the services, not the date you received **Prior Authorization**.
- If you lose Coverage under this plan, services received after Coverage ends will not be Covered, even if we provided **Prior Authorization**.

Prior Authorization Decisions – Non-Emergency

We will evaluate non-emergent **Prior Authorization** requests and advise you and your Practitioner/Provider of our decision within **seven working days after receiving all needed information**.

Prior Authorization Decision – Expedited (Accelerated)

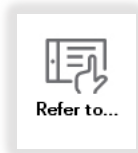
If your medical condition requires that we make a **Prior Authorization** decision quickly, we will notify you and your Practitioner/Provider of an expedited decision, within **24 hours** of our receipt of the written or verbal request for an expedited decision.

Prior Authorization Review – Initial Adverse Determination

If we do not approve the **Prior Authorization** request (Adverse Determination) we will notify you and your Practitioner/Provider by telephone (or as required by your medical situation) **within 24 hours** of making our decision.

We will also notify you and your Practitioner/Provider of the Adverse Determination by written or electronic communication sent within **one working day** of a telephone notice. Our notice will include:

- Reasons for a Medical Necessity denial including why the requested healthcare service is not Medically Necessary.
- The reason for a denial based on lack of coverage and a reference to all healthcare plan provisions on which the denial is based and a clear and complete explanation of why the Healthcare Service is not Covered.
- An explanation of how you may request our internal review of our Adverse Determination including any forms that must be used and completed.



Please see the **Complaints, Grievances and Appeals Section** for information regarding how to request an internal review of any Adverse Determinations that we make.

Presbyterian will not retroactively deny authorization if a provider relied upon a written prior authorization from Presbyterian, received prior to providing the benefit, except in those cases where there was material misrepresentation or fraud by the provider.

Prior Authorization Requirement

Certain types of care require **Prior Authorization** by us.

This means that you or your Provider must ask us to approve the care before you receive it.

A complete and current list of the services subject to **Prior Authorization** can be found here: https://onbasext.phs.org/PEL/DisplayDocument?ContentID=OB_000000002930. The prescription drugs that are subject to a **Prior Authorization** requirement can be found at <https://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001476.pdf>.

We may decline payment for unauthorized care. If your Provider is in-network, and you did not agree to receive unauthorized care, your Provider cannot bill you for the care. If you received unauthorized care from a Provider who is not In-network, you may be fully responsible for the resulting bills.

We do not require **Prior Authorization** for:

- Mental health or substance use disorder services:
 - Acute or immediately necessary care;
 - Acute episodes of chronic mental health or substance use disorder conditions;
 - Initial in-network inpatient or outpatient substance use treatment services.
- Prescription drugs used for the treatment of substance use disorders, when a generic version is available, the medication is medically necessary and is approved by the Federal Food and Drug Administration;
- Emergency services;
- Contraception services that are not subject to any Cost-sharing; or
- Obstetrical or gynecological ultrasounds.

However, we require **Prior Authorization** for continued Inpatient care if you are admitted to a Hospital for emergency treatment, but your condition is stabilized. You or your Provider must notify us as soon as possible from when you begin receiving emergency Inpatient treatment, and within 24 hours after the emergency ends and your condition stabilizes.

Prior Authorization Process

Your In-network Provider is responsible for knowing what care requires **Prior Authorization**, and for submitting a **Prior Authorization** request to us.

We will give any Provider access to all necessary forms and instructions for making the request. An Out-of-network Provider is not required to submit a **Prior Authorization** request for you. If you visit one of these Providers and that Provider will not submit a **Prior Authorization** request, you may submit a **Prior Authorization** request on your own behalf, or on behalf of a Dependent. We will help you obtain required documents and show you the guidelines that apply to the request. However, because your Provider should be able to gather required information and submit it sooner, we encourage you to have your Provider request **Prior Authorization** whenever possible.

Prior Authorization Review Timelines

If we do not deny a complete **Prior Authorization** request within these time frames, the request is automatically approved:

- **Urgent Care or Prescription Drugs:** If you require urgent medical care, behavioral health care or a Prescription Drug, we will resolve the request within **24 hours**.
- **Non-Urgent Medicine:** If you do not have an urgent need for a Prescription Drug, we will resolve the request within three business days if your Provider:
 - Uses the **Prior Authorization** request form approved by the New Mexico Office of Superintendent of Insurance;
 - Requests an exception from an established step therapy process; or
 - Requests to prescribe a drug that we do not usually cover.
- **Other Requests:** We will resolve all other requests within **seven business days**.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff can answer questions your Provider might have concerning required information or any aspect of the request submission process. If we require additional information to evaluate a request, we will request it from your Provider. Your Provider will have at least **four hours** to provide requested information in connection with an urgent **Prior Authorization** request and at least **two calendar days** for any other type of request.

Why We Review

Our review of a **Prior Authorization** request will determine if the proposed care involves a covered service, is Medically Necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning Medical Necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional. **Prior authorization** does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review

If you received care without a required **Prior Authorization**, we may allow your Provider to request authorization retrospectively. Our utilization management team will assist your Provider in the submission of a retrospective authorization request. However, we do not routinely review or authorize care retrospectively. To avoid uncertainty, it is always best to request **Prior Authorization**.

Behavioral Health Care

Requests for behavioral health care and Prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and Prescriptions.

Authorization Denial

We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process is included in this document. Please refer to the Table of Contents. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

Record of Prior Authorization

A record of each prior authorization request and its associated documentation will be kept on file by Presbyterian in accordance with state and federal law.

Prescription Drug Prior Authorization Protocols

After January 1, 2014, a health care plan shall accept the uniform prior authorization form developed pursuant to Sections 2 59A-2-9.8 NMSA 1978 and 3 61-11-6.2 NMSA 1978 of this 2013 act as sufficient to request prior authorization for prescription drug benefits.

No later than twenty-four months after the adoption of national standards for electronic prior authorization, a health insurer shall exchange prior authorization requests with providers who have e-prescribing capability.

If a health care plan fails to use or accept the uniform prior authorization form or fails to respond within three business days upon receipt of a uniform prior authorization form, the prior authorization request shall be deemed to have been granted.

As used in this section, "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments but does not include:

- a person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only

or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;

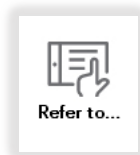
- a physician or a physician group to which a health care plan has delegated financial risk for prescription drugs and that does not use a prior authorization process for prescription drugs; or
- a health care plan or its affiliated providers, if the health care plan owns and operates its pharmacies and does not use a prior authorization process.

Benefits

This Healthcare Benefit Plan offers Coverage for a wide range of Healthcare Services. This Section gives you the details about your benefits, Prior Authorization and other requirements, Limitations and Exclusions.

Specifically Covered

This Healthcare Benefit Plan helps pay for healthcare expenses that are Medically Necessary and Specifically Covered in this Plan. Specifically Covered means only those Healthcare Benefits that are expressly listed and described in the **Benefits Section** of the Plan. In addition, you should refer to the **Exclusions Section** that lists services that are not Covered under your Healthcare Benefit Plan. All other benefits and services not specifically listed as Covered in the Benefits Section shall be **excluded, except for Clinical Preventive Health Services and except as required by state or federal law.**



There are no annual or lifetime limits on the dollar value of essential health benefits, as defined under the Affordable Care Act. Presbyterian Insurance Company will not deny or limit coverage, deny or limit coverage of a claim, or impose additional Cost-sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

Specifically, Covered Benefits are subject to the **Limitations, Exclusions, Prior Authorization** and other provisions of this Plan.

Medical Necessity

This Healthcare Benefit Plan helps pay for healthcare expenses that are Medically Necessary and specifically Covered in this Plan.

Medical Necessity or Medically Necessary means Healthcare Services determined by a Practitioner/Provider, in consultation with Presbyterian Insurance Company (PIC), to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines we developed consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral or mental health condition, illness, injury, or disease.



Experimental or Investigational drugs, medicines, treatments, procedures, or devices are not Covered. This does not include Clinical Trials. Please refer to Clinical Trials in the **Benefit Section** of this Plan.

Care Coordination and Case Management

Care Coordination and Case Management are provided by our Care Coordination Department which is staffed with registered nurses, social workers, behavioral health specialists and non-licensed care coordinators that coordinate Covered and non-Covered Healthcare Services for you when you have ongoing or complex diagnoses.

The role of the care coordinator is to support and educate you and other Members, so that you are able to make informed healthcare decisions. Our ongoing communication to you and to other Members who may have a chronic illness can trigger prompt intervention and help in the prevention of avoidable episodes of illness. We are committed to the personal service that care management provides to you when you are in need.

When you are in the Hospital, our care coordinators can work with the Hospital, their discharge planners and your Practitioners to make sure you get the appropriate level of care and to coordinate your care after you leave the Hospital.

Disease Management (DM) health coaches work with you to help you better manage your chronic disease, such as Asthma, Coronary Artery Disease, Diabetes, and/or Hypertension. A licensed nurse works with you to gain a better understanding of your condition, establish self-management goals, and provide coaching to assist you in making lifestyle modifications.

At the request of an insured, an insurer may facilitate communication between mental health or substance use disorder services providers and the insured's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the insured.

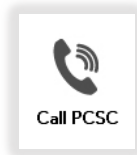
PresRN

Presbyterian Insurance Company Members have access to PresRN, our local nurse advice line available **24 hours** a day, **seven days** a week, including holidays. PresRN is a no-cost service for Presbyterian Insurance Company Members. Please call at **(505) 923-5570** or **1-866-221-9679**.

Health Management Programs

Members have access to resources that support personal health management including online tools, print materials and programs or services to help enhance quality of life in three areas: staying healthy, preventing illness and living with a chronic condition. We help you reach optimum health through educational tools (such as those available on the myPRES Member Portal), Preventive Health Guidelines (such as Mammography and childhood immunizations) as

well as with disease management for conditions such as Asthma, Coronary Artery Disease, Diabetes, and/or Hypertension.



If you would like more information about these services, visit <https://www.phs.org/tools-resources/member>. Members can also call our Presbyterian Customer Service Center at (505) 923-6980 or 1-800-923-6980, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call TTY 711.

Other Programs and Services

Talkspace

Messaging therapy offers members age 14 and older behavioral health coaching with licensed behavioral therapists via text, video or audio messaging at a time and place that is convenient for them. Go to www.talkspace.com/php to access the program.

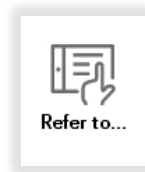
On to Better Health

This interactive software offers an alternative to traditional mental health and substance use disorder care by providing access to tools and resources that are easy to use, confidential and available 24/7. Try the program by going to www.ontobetterhealth.com/php. Create an account and answer a few questions to gain access to the Health Better Services available to you.

Assist America

You have the protection of Assist America's global emergency travel assistance services 24 hours a day, 365 days a year. This unique program immediately connects you to services when experiencing a medical emergency while traveling 100 miles or more away from a permanent residence or in another country. First, download the free Assist America Mobile App, then log in with reference number **01-AAPXI-10071**. For questions, contact Assist America's Operations Center at **1-800-872-1414** (or **+1-609-986-1234** outside of the USA).

MyChart



Members with a Presbyterian Medical Group provider can send electronic messages and communicate with their care team, request prescription renewals and schedule office or telephone visits. You can also view medical records, lab and radiology reports, procedures, and test results. For details, visit www.phs.org/mychart.

Wellness at Work

This online tool helps you create personalized health improvement plans and features a powerful Personal Health Assessment (PHA) tool to help identify personal health risks and provide recommendations for improving those risks. To participate, visit www.phs.org and register or login onto myPRES.

TytoHome

Presbyterian is offering TytoHome Medical Exam kit for select plans. This device allows you to provide an enhanced video visit experience and provides clinicians with clinical-level, real-time remote exam data to deliver top-quality diagnoses and treatment with maximum convenience. TytoHome comes with:

- Exam camera and thermometer
- Stethoscope adaptor for heart, lung, and abdominal sounds
- Tongue depressor for throat images
- Otoscope adaptor for ear exams

Covered Benefits

Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services, and Observation Services



This benefit has one or more exclusions as specified in the **Exclusions Section**.

Urgent Care

This Plan covers acute Urgent Care triage 24 hours per day, 7 days per week, when those services are needed immediately to prevent jeopardy to your health. Urgent Care is Medically Necessary medical or surgical procedures, treatments, or Healthcare Services you receive in an Urgent Care Center or in a Practitioner's/Provider's office for an unforeseen condition due to illness or injury. Urgent conditions are not life-threatening but require prompt medical attention to prevent a serious deterioration in your health.

If you believe the condition to be treated is life threatening, you should seek Emergency Healthcare Services as outlined below.

Emergency Healthcare Services

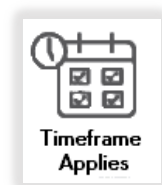
This Plan covers acute Emergency Healthcare Services **24 hours** per day, **7 days** per week, when those services are needed immediately to prevent jeopardy to your health. If Emergency Healthcare Services are administered by either an In-network or Out-of-network Practitioner/Provider, benefits for the initial treatment are paid at the In-network benefit level.

If you, as a result of Emergency Healthcare Services, are admitted to an Out-of-network Hospital, you may choose to be transferred to a Hospital that is in our Practitioner/Provider PPO network (In-network). You must be medically stable and able to be safely transferred. Refer to Emergency Medical Transportation in the *Summary of Benefits and Coverage* for the required Cost Sharing for inter-facility transportation costs. If you choose to remain at an Out-of-network

Hospital after you are medically stable and able to be safely transferred, Out-of-network benefits will apply.

We will provide reimbursement when you receive healthcare procedures, treatments or services delivered after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Disfigurement to the person



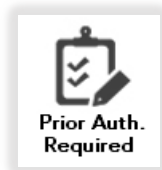
Prior Authorization is not required for Emergency Healthcare Services. If you are admitted as an Inpatient to the Hospital, you or your Practitioner needs to notify us within **48 hours** so we can review your Hospital stay.

For Emergency Healthcare Services outside of our Service Area, you may seek Emergency Healthcare Services from the nearest appropriate facility where Emergency Healthcare Services can be rendered. These services will be Covered as In-network services. Non-emergent follow-up care received from an Out-of-network Practitioner/Provider is Covered at the Out-of-network level of benefits.

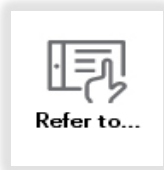
Observation Services

Observation services are defined as Outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff which are reasonable and necessary to:

- Evaluate an outpatient's condition
- Determine the need for a possible admission to the Hospital
- When rapid improvement of the patient's condition is anticipated or occurs



When a Hospital places a patient under Outpatient Observation, it is based upon the Practitioner's/Provider's written order. To transition from Observation to an Inpatient admission, our level of care criteria must be met. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient stays. Medical criteria will also be considered. **Observation Services for greater than 24 hours will require Prior Authorization.** It is the responsibility of the facility to notify us.



All Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services, and Observation Services whether provided within or outside of our Service Area are subject to the **Limitations** listed in the **Limitations Section** and the **Exclusions listed in the Exclusions Section.**

Ambulance Services



This benefit has one or more exclusions as specified in the **Exclusions Section.**

The following types of Ambulance Services are Covered:

- Emergency Ambulance Services
- High-Risk Ambulance Services
- Inter-facility Transfer services

Emergency Ambulance Services are defined as ground or air Ambulance Services delivered to a Member who requires Emergency Healthcare Services under circumstances that would lead a Reasonable/Prudent Layperson acting in good faith to believe that transportation in any other vehicle would endanger your health. **Emergency Ambulance Services are Covered only under the following circumstances:**

- For transportation to the nearest appropriate facility where Emergency medical Healthcare Services and treatment can be rendered. Such services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- We will not pay more for air Ambulance Services than we would have paid for ground Ambulance Services over the same distance unless your condition renders the utilization of such ground transportation services medically inappropriate.
- In determining whether you acted in good faith as a Reasonable/Prudent Layperson when obtaining Emergency Ambulance Services, we will take the following factors into consideration:
 - Whether you required Emergency Healthcare Services, as defined above
 - The presenting symptoms
 - Whether a Reasonable/Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health
 - Whether you were advised to seek an Ambulance Service by your Practitioner/Provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Plan

- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols

Ambulance Service (ground or air) to the coroner's office or to a mortuary is not Covered, unless the Ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.

High-Risk Ambulance Services are defined as Ambulance Services that are:

- Non-emergency
- Medically Necessary for transporting a high-risk patient
- Prescribed by your Practitioner/Provider

Coverage for High-Risk Ambulance Services is limited to:

- Air Ambulance Service when Medically Necessary. However, we will not pay more for air Ambulance Service than we would have paid for transportation over the same distance by ground Ambulance Services, unless your condition renders the utilization of such ground Ambulance Services medically inappropriate.
- Maternity/Neonatal Ambulance Services, including ground or air Ambulance Service to the nearest Tertiary Care Facility is limited to:
 - The medically high-risk pregnant woman with an impending delivery of a potentially viable infant.
 - When necessary to protect the life of a newborn.
- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

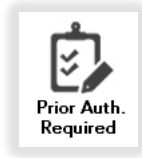
Inter-facility Transfer Ambulance Services are defined as ground or air Ambulance Service between Hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are Covered only if they are:

- Medically Necessary
- Prescribed by your Practitioner/Provider
- Provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel

Bariatric Surgery

Surgical treatment of morbid obesity (bariatric surgery) is Covered only if it is Medically Necessary as defined in this Plan.

Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m² or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions; and **Prior Authorization** is required and services must be performed at an In-network facility that is designated by Presbyterian Insurance Company and designated as an accredited bariatric surgery center by the American Society of Metabolic and Bariatric Surgery/American College of Surgeons.



Biomarker Testing

Biomarker Testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a member's disease or condition is covered if the test is supported by medical and scientific evidence such as FDA approval, CMS national or local coverage determinations, or nationally recognized clinical practice guidelines. Biomarker testing may be subject to cost sharing consistent with that imposed on testing benefits.

Clinical Trials



This benefit has one or more exclusions as specified in the Exclusions Section.

If you are a qualified individual participating in an approved Clinical Trial, you may receive coverage for certain routine patient care costs incurred in the trial.

A **qualified individual** is someone who is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either (1) the referring healthcare professional is a participating provider and has concluded that participation in the clinical trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation would be appropriate.

An **approved Clinical Trial** is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition and is:

1. Conducted under an investigational new drug application reviewed by the Food and Drug Administration;
2. A drug trial that is exempt from having such an investigational new drug application; OR
3. Is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - a. The National Institutes of Health;
 - b. The Centers for Disease Control and Prevention;
 - c. The Agency for Healthcare Research and Quality;
 - d. The Centers for Medicare & Medicaid Services;

- e. A cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs;
- f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; OR
- g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the Secretary of Health and Human Services determines that the study has been reviewed and approved through a system of peer review that (i) is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

Routine patient care costs that are covered are items or services that would be covered for a member or beneficiary who is not enrolled in a clinical trial. All applicable plan limitations for coverage of Out-of-network care will still apply to routine patient costs in clinical trials.

Drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration (FDA), whether or not that organization has approved the drug for use in treating the patient’s particular condition, but only to the extent that the drug is not paid for the manufacturer, distributor or provider of the drug.

Routine patient care costs **do not** include:

- The actual clinical trial or the investigational service itself;
- Cost of data collection and record keeping that would not be required but for the clinical trial; Items and services provided by the clinical trial sponsor without charge;
- Travel, lodging, and per diem expenses;
- A service that is clearly inconsistent with widely accepted and established standards for a particular diagnosis; and
- Any other services provided to clinical trial participants that are necessary only to satisfy the data collection needs of the clinical trial.

If the benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

Certified Hospice Care



This benefit has one or more exclusions as specified in the Exclusions Section.

Benefits for Inpatient and in-home Hospice services are Covered if you are terminally ill. Services must be provided by an approved Hospice program during a Hospice benefit period and

will not be Covered to the extent that they duplicate other Covered Services available to you. Benefits that are provided for by a Hospice or other facility require **Prior Authorization**. The Hospice benefit period is defined as follows:

- Beginning on the date your Practitioner/Provider certifies that you are terminally ill with a life expectancy of six months or less.
- If you require an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and your Practitioner/Provider must **re-authorize** your medical condition to us.
- You must be a Covered Member throughout your Hospice benefit period.

The following services are Covered:

- Inpatient Hospice care
- Practitioner/Provider visits by Certified Hospice Practitioner/Providers
- Home Health Care Services by approved home health care personnel
- Physical therapy
- Medical supplies
- Prescription Drugs and Medication for the pain and discomfort specifically related to the terminal illness
- Medical transportation
- Respite care (care that provides a relief for the caregiver) for a period not to exceed **five continuous days** for every **60 days** of Hospice care. No more than two respite care stays will be available during a Hospice benefit period.

Clinical Preventive Health Services



This benefit has one or more exclusions as specified in the Exclusions Section.

We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.

We will provide Coverage for preventive benefits, as defined by the Affordable Care Act (ACA), without cost sharing regardless of sex assigned at birth, gender identity, or gender of the individual. Preventive care and treatment of sexually transmitted infection is covered at no charge.

Clinical Preventive Health Services Coverage is provided for services under four broad categories:

- Screening and Counseling Services
- Routine Immunizations

- Childhood Preventive Services
- Preventive Services for Women

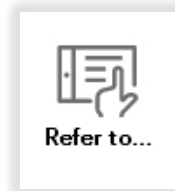
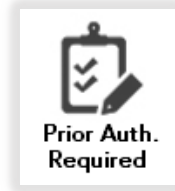
You can review the recommended clinical preventive health services at [Preventive Care Guidelines | Presbyterian Healthcare Services \(phs.org\)](https://www.phs.org/preventive-care-guidelines).

Screening and Counseling Services

Screenings and counseling services will provide coverage for evidence-based services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force for individuals in certain age groups or based on risk factors. Key screenings include but are not limited to:

- Abdominal aortic aneurism screening for men ages **65 to 75 years** old who have ever smoked.
- Anxiety in Children and Adolescents: Screening ages **8 to 18 years** old.
- Prediabetes and Type 2 diabetes mellitus screening for adults ages **35 to 70 years** old who are overweight or obese.
- Screening for human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and domestic violence and abuse.
- Heart Artery Calcification scans are a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function. These scans are Covered for individuals between the ages of **45-65 years**. Refer to the Heart Artery Calcification section for more details.
- Falls prevention screening for adults **age 65** or older.
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- Hepatitis B screenings for persons at high risk of infection.
- Hepatitis C screenings for adults ages **18 to 79 years** old.
- Latent tuberculosis screening for high-risk populations.
- Lung cancer screenings for ages **50 to 80 years** with a history of smoking.
- Preventive Physical Examinations.
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication adults aged **40 to 75 years** who have one or more cardiovascular risks.
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam.
- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level.
- Periodic stool examination for the presence of blood for all persons **45-75 years** of age or older.

- Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:
 - Fecal occult blood testing (FOBT).
 - Flexible sigmoidoscopy.
 - Colonoscopy, and polyp removal when performed as a screening:
 - anesthesia services are also at no Cost-Share to Covered members when performed as part of Colonoscopy screening.
 - Virtual colonoscopy – requires **Prior Authorization**.
 - Double contrast barium enema.
- After a colonoscopy, any pathology exam that's required for a biopsy anesthesia a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test.
- Smoking Cessation Program – refer to Smoking Cessation Counseling/Program in this Section.
- Screening to determine the need for vision and hearing correction in children.
- Periodic glaucoma eye test.
- Healthy Weight and Weight Gain in Pregnancy: Behavioral Counseling Interventions
- Hypertension in Adults: Screening adults **18 years or older** without known hypertension.
- Syphilis infection screening in persons who are at an increased risk for infection and pregnant women.
- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV, STIs, and counseling, as well as counseling for drug and tobacco use, healthy eating and other common health concerns.
- Health education and consultation from In-network Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members **19 years** of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.
- Certain prescription drugs for preventive care, the treatment of illness, behavioral health, or substance use disorders will be Covered at No Charge to you, when obtained from a participating pharmacy. See your Plan's Covered drug list for details.



Mammography Services

This Plan provides coverage for low-dose screening mammograms for determining the presence of breast cancer. This coverage makes available one baseline mammogram to persons **age 35-39**, one mammogram biennially to persons **age 40-49**, and one mammogram annually to persons **age 50 and over**. After July 1, 1992, coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging

facilities that have met American College of Radiology accreditation standards for mammography. These scans are Covered.

Additionally, medically necessary and clinically appropriate diagnostic breast examinations using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound that evaluates an abnormality seen or suspected from a screening examination for breast cancer; or detected by another means of examination and medically necessary and clinically appropriate supplemental breast examinations using breast magnetic resonance imaging or breast ultrasound that is used to screen for breast cancer when there is no abnormality seen or suspected; and based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer are covered.

Pre-Exposure Prophylaxis Coverage Summary

Your plan includes coverage for PrEP medication, as appropriate for you, and essential PrEP-related services without Cost sharing, the same as any other preventive drug or service. This means that you do not have to make a Copayment, pay Coinsurance, satisfy a Deductible or pay Out-of-pocket for any part of the benefits and services listed in this summary if you receive them from an In-network provider.

You may be required to pay a Copayment, Coinsurance, and/or a Deductible if you receive PrEP medication or PrEP-related services from an Out-of-network Provider if the same benefit or service is available from an In-network Provider.

What is Covered?

- At least one FDA-approved PrEP drug, with timely access to the PrEP drug that is medically appropriate for the enrollee, as needed.
- HIV testing.
- Hepatitis B and C testing.
- Creatinine testing and calculated estimated creatine clearance or glomerular filtration rate.
- Pregnancy testing for individuals with childbearing potential.
- Sexually transmitted infection screening and counseling.
- Adherence counseling.
- Office visits associated with each preventive service listed above.
- Quarterly testing for HIV and STIs, and annually for renal functions, required to maintain a PrEP prescription.

Grievance and Appeals Process

If you were charged cost sharing for coverage of PrEP medication or PrEP-related services on or after January 1, 2021, please call our customer service at **(505) 923-6980**. If you would like to submit a grievance, the customer service representative can submit the request for you.

If you are denied coverage of a PrEP-related service(s), we will inform you in writing of the denial. Our notice to you will explain why we denied the coverage and will provide you with instructions for filing a grievance if you want to contest our decision. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP coverage denial as follows:

Phone: (505) 923-5644 or 1-800-923-6980

Address: Presbyterian Insurance Company, Inc.,
Attn: Appeals and Grievance Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Fax: (505) 923-6111

Email: gappeals@phs.org

Exception Process

If you have been denied coverage of a PrEP medication, we will inform you in writing of the denial. Our notice to you will provide you with instructions for filing an exception request if the medication that is most appropriate for your circumstances is not included in the drug *Formulary*. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP medication coverage denial by contacting Customer Service at the number on the back of your ID card.

Standard Review

- We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within 72 hours following receipt of your request.

Expedited Review

- If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a non-*formulary* drug, you can request an expedited review. We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within 24 hours following receipt of your request.

If our initial determination is overturned, we will provide coverage for the PrEP medication or PrEP related service that is medically appropriate for you for the duration of the treatment.

Routine Immunizations

Routine Immunization includes Coverage for Adult and Child Immunizations (shots or vaccines), in accordance with the recommendations of:

- The Advisory Committee on Immunization Practices Centers for Disease Control and Prevention.
- The U.S. Preventive Services Task Force (USPSTF)
 - HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).

Childhood Preventive Health Services

Childhood Preventive Health Services includes Coverage for Well-Child Care in accordance with the recommendations of the U.S. Preventive Services Task Force (USPSTF). We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider. You can review the recommended clinical preventive health services at <https://www.phs.org/tools-resources/patient/preventive-care-guidelines>.

With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Key preventive care includes:

- Anxiety in Children and Adolescents: Screening ages **8 to 18 years** old.
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sports, school, or camp activities.
- Hearing and Vision screening for correction. This does not include routine eye exams or Eye Vision and Hearing screening to determine Refractions performed by eye care specialists. One Eye Refraction per Contract Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases.
- Prevention of Dental Caries in Children Younger Than **5 Years**: Screening and Interventions.
- Pediatric Vision – Please refer to the Rider at the end of this Plan for benefit coverage and details.
- Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
- Behavioral Assessments.
- Screening for Alcohol and drug use, anemia, blood pressure, congenital hypothyroidism, depression, developmental development and surveillance, dyslipidemia, hematocrit/hemoglobin or sickle cell, lead, obesity, oral health, STIs, Phenylketonuria (PKU) and Tuberculin testing.

- Skin cancer prevention behavioral counseling.
- Counseling from Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members under **19 years** of age, this includes (as deemed appropriate by the Member's Practitioner/Provider or as requested by the parents or legal guardian) education information on Alcohol and Substance Use Disorder, STIs, and contraception.
- Preventive benefits, as defined by the Affordable Care Act (ACA) for all recommended preventive services, including services related to pregnancy, preconception, and prenatal care.

Preventive Health Services for Women

We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.

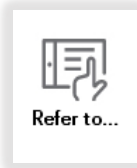
You can review the recommended clinical preventive health services at

<https://www.phs.org/tools-resources/patient/preventive-care-guidelines>.

With respect to women, evidence-informed preventive care and screenings for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Key preventive care includes but is not limited to:

- Well-woman visits to include adult and female-specific screenings and preventive benefits.
- Breast Cancer: Medication Use to Reduce Risk.
- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for **one year** after delivery.
- Cervical cancer screening every three years for women **21-65 years of age** who are at average risk.
- Chlamydia and gonorrhea screenings for sexually active women age **25 years** or younger and for older women at increased risk for infection.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Coverage for contraception is not subject to Cost Sharing, Utilization Review, **Prior Authorization**, step-therapy requirements, or any other restrictions or delays on coverage.
 - Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pe1_00052739
 - Coverage of a six-month supply of contraceptives at one time, provided that the contraceptives are prescribed and self-administered.
- Counseling and screening for HIV, STIs and domestic violence and abuse.
- Counseling interventions for pregnant and postpartum persons who are at an increased risk of perinatal depression.

- Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- HIV screening and counseling for sexually active and pregnant women. For pregnant women, the screening will be covered at any point of the pregnancy, even those who present in labor with an unknown status.
- Cervical cancer screening every three years for women **21-65 years of age** who are at average risk.
- HPV DNA test: High-risk HPV DNA testing every **three years** for women with normal cytology results.
- HPV vaccine coverage for HPV as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).
- Preeclampsia screenings in pregnant women throughout pregnancy.
- Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication for pregnant persons at high risk for preeclampsia.
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling.
- Sterilization services for women only. Other services, performed during the procedure, are subject to deductible and coinsurance as outlined in your *Summary of Benefits and Coverage*.
- Urinary incontinence screening.



You can obtain additional information about Women’s Preventive Services recommendations and guidelines on the HealthCare.gov website at <https://www.healthcare.gov/preventive-care-women/>.

Complementary Therapies



This benefit has one or more exclusions as specified in the **Exclusions Section**.

Acupuncture

Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by your Practitioner/Provider.

These benefits cover acupuncture and acupressure treatment. These benefits cover acupuncture and acupressure treatment. Services are **limited** to 20 visits per Contract Year unless for

rehabilitative or habilitative purposes. There are no limits on services for habilitative or rehabilitative services. The visit limits apply to services for non-habilitative or non-rehabilitative services.



It is recommended that Acupuncture be part of a coordinated plan of care approved by your Practitioner/Provider.

Acupuncture services must be provided by an appropriately licensed and credentialed healthcare provider (i.e., a doctor of Oriental Medicine).

Chiropractic Services

Chiropractic services are available for specific medical conditions and are not available for maintenance therapy such as routine adjustments. Chiropractic services are subject to the following:

- Presbyterian will not impose a member cost share for physical rehabilitation & Chiropractic services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applicable or if a copay is applicable. The physical rehabilitation services must be performed by, or under the direction of a licensed physical therapist, occupational therapist or speech therapist.
- The Chiropractic services must be performed by a Chiropractic physician.
- The Practitioner/Provider determines in advance that Chiropractic treatment can be expected to result in Significant Improvement in your condition within a period of two months.
- Chiropractic treatment is specifically **limited** to treatment by means of manual manipulation, i.e., by use of hands, and other methods of treatment approved by us including, but not limited to, ultrasound therapy.
- Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. We do not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment.
- Chiropractic X-rays are only Covered when performed by a Chiropractor, unless clinically relevant X-rays already exist.



Chiropractic services are **limited** to 20 visits per Contract Year unless for rehabilitative or habilitative purposes. There are no limits on services for habilitative or rehabilitative services. The visit limits apply to services for non-habilitative or non-rehabilitative services.

Biofeedback



Biofeedback is **only Covered** for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

COVID-19

As a Presbyterian Insurance Company Member, there will be no cost to you for anything related to COVID-19 screening, testing, medical treatment, or vaccinations, including boosters. You will not pay Copays, Deductibles or Coinsurance for visits related to COVID-19, whether at a clinic, Hospital or using remote care.

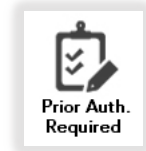
Dental Services (Limited)



This benefit has one or more exclusions as specified in the **Exclusions Section**.

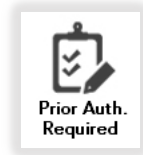
Dental benefits will be provided in connection with the following conditions when deemed Medically Necessary except in an emergency situation as described in the **Benefits Section, Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services and Observation Services**. Covered Services are as follows:

- Accidental Injury to sound natural teeth, jawbones or surrounding tissue. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury and will not be Covered.**
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Hospitalization, day surgery, Outpatient and/or anesthesia for non-Covered dental services, are Covered, if provided in a Hospital or ambulatory surgical center for dental surgery, **Prior Authorization** may be required. Plan benefits for these services include coverage:
 - For Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
 - For Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
 - For Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that



treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.

- For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- For other procedures for which Hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- **Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)**
 - The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) are subject to the same conditions, limitations, and may require Prior Authorization as they apply to treatment of any other joint in the body.



Diabetes Services



This benefit has one or more exclusions as specified in the **Exclusions Section**.

Covered Benefits are provided if you have insulin dependent (Type I) diabetes, non-insulin dependent (Type 2) diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). We will guarantee Coverage for the equipment, appliances, Prescription Drug/Medications, insulin or supplies that meet the United States Food and Drug Administration (FDA) approval, and are the medically accepted standards for diabetes treatment, supplies and education.

Coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given policy.

Diabetes Education and Self-Management Training

The following benefits are available when received from a Practitioner/Provider who is approved to provide diabetes education:

- Medically Necessary diabetes education and self-management training visits upon the diagnosis of diabetes

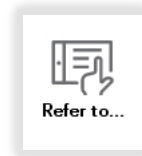
- Visits following a Practitioner/Provider diagnosis that represents a significant change in condition or symptoms requiring changes in the patient’s self-management
- Visits when re-education or refresher training is prescribed by a healthcare Practitioner/Provider with prescribing authority
- Telephonic visits with a Certified Diabetes Educator (CDE)
- Medical nutrition therapy related to diabetes management

Practitioners/Providers who are approved diabetes educators must be a registered, certified or licensed Healthcare Professional with recent education in diabetes management.

Diabetes supplies, equipment, appliances and services

The following equipment, supplies, appliances, and services are Covered when prescribed by your Practitioner/Provider and when obtained through the designated network Provider:

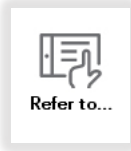
- Insulin pumps.
- Insulin Management Systems (Omnipod).
- Formulary Continuous Glucose Monitoring (CGM) including system, sensor, and transmitter.
- Medically Necessary Covered Podiatric appliances for prevention of feet complications associated with diabetes. Refer to the **Durable Medical Equipment Benefits Section**.
- Formulary oral diabetic agents for controlling blood sugar levels.
- Glucagon emergency kits.
- Formulary Insulin Syringes.
- Injection aids, including individuals with disabilities, including those adaptable to meet the needs of the legally blind.
- Formulary Blood Glucose Monitors/Meters, including specialized monitors/meters for the legally blind.
- Formulary Test strips for blood glucose monitors.
- Formulary Lancets and lancet devices.
- Visual reading urine ketone strips.
- Alcohol swabs.



Some services may require Prior Authorization. Please contact our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-6980 or 1-800-923-6980**. TTY users may call **711**. You may also visit <https://www.phs.org/doctors-services/supporting-services/pharmacy-services>.

Presbyterian will provide reimbursement within 30 days when a member paid out-of-pocket due to untimely receipt of ordered equipment, appliances, supplies and insulin or other prescription drugs. Presbyterian will pay interest at the rate of 18% per year on the amount of reimbursement due to a covered person if not paid within 30 days. Presbyterian does not require more than one **Prior Authorization (PA)** per policy year, per prescribed diabetes drug or item.

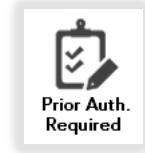
Diagnostic and Imaging Services (tests performed to determine if you have a medical problem or to determine the status of any existing medical conditions.)



Coverage is provided for Diagnostic Services when Medically Necessary and provided under the direction of your Practitioner/Provider. Some services require **Prior Authorization**. Refer to the **Prior Authorization Section** for **Prior Authorization** requirements.

Examples of Covered procedures include, but are not limited to, the following:

- Artery calcification testing (plan year 2022 and after)
- Computerized Axial Tomography (CAT) scans – requires **Prior Authorization**
- Magnetic Resonance Angiogram (MRA) tests, Magnetic Resonance Imaging (MRI) tests – require **Prior Authorization**
- Sleep disorder studies in home or facility. (In facility sleep studies require **Prior Authorization**)
- Bone density studies
- Clinical laboratory tests (may require **Prior Authorization**)
- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiology/X-ray services
- Diagnostic breast exams
- Supplemental breast exams
- Biomarker testing



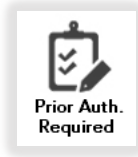
Diagnostic service includes services like mammography, PAP Smears and colonoscopies that are also considered Preventive and are provided to you at \$0 Cost Sharing. Some services like exploratory surgery, angiograms, **imaging**, or follow-up procedures to Preventive services can also be diagnostic, but not Preventive and would apply the appropriate Cost Sharing (Copay, Coinsurance) based on the service.

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids



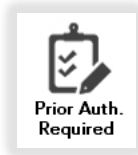
This benefit has one or more exclusions as specified in the **Exclusions Section**.

Durable Medical Equipment



Durable Medical Equipment is equipment that is Medically Necessary for treatment of an illness or Accidental Injury or to prevent further deterioration. This equipment is designed for repeated use, used for treatment of a medical condition or illness and includes items such as oxygen equipment, functional wheelchairs, and crutches. Some Durable Medical Equipment may require **Prior Authorization**. Only Durable Medical Equipment considered standard and/or basic as defined by nationally recognized guidelines are Covered.

Custom Orthotic Appliances

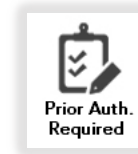


Custom Orthotic Appliances include braces and other external devices used to correct a body function. Custom Orthotic Appliances must be Medically Necessary and may require **Prior Authorization**. Cost-sharing requirements are not more restrictive than the Cost-sharing requirements applicable to this Plan's medical and surgical benefits, including those for internal devices.

Custom Orthotic Appliances are subject to the following **limitations**:

- Foot Orthotics or shoe appliances are not Covered, except for our Members with diabetic neuropathy or other significant neuropathy.
- Prefabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for our Members in accordance with nationally recognized guidelines.
- Covered Custom Orthotic Appliances including:
 - Podiatric appliances for prevention of feet complications associated with diabetes.

Prosthetic Devices



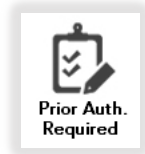
Prosthetic Devices are artificial devices, which replace or augment a missing or impaired part of the body. The purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are Covered when they replace a limb or other part of the body, after accidental or surgical removal and/or when the body's growth necessitates replacement. Prosthetic Devices must be Medically Necessary and may require **Prior Authorization**. Cost-sharing requirements are not more restrictive than the Cost-sharing requirements applicable to this Plan's medical and surgical benefits, including those for internal devices.

Examples of Prosthetic Devices include, but are not limited to:

- Breast prostheses when required because of mastectomy and prophylactic mastectomy:
 - Prosthetics related to other medically necessary services for Gender Confirmatory Therapy and Gender Affirming Care are Covered.
- Artificial limbs.
- Prosthetic eye.

- Prosthodontic appliances.
- Penile prosthesis.
- Joint replacements.
- Heart pacemakers.
- Tracheostomy tubes and cochlear implants.

Repair and Replacement of Durable Medical Equipment, Prosthetics and Custom Orthotic Devices



Repair and replacement of Durable Medical Equipment, Prosthetics and Custom Orthotic Devices requires **Prior Authorization**, except when provided for diabetes related services. All diabetes related services are provided in accordance with State law. Please refer to the Diabetes Services Section.

Repair and replacement are Covered when Medically Necessary due to change in your physiological condition, irreparable change in the condition of the device, or repairs would be more than 60% of the cost of a replacement, wear or after the product's normal life expectancy has been reached. If the device is less than 3 years old and prescribed by a health care provider, Prior Authorization may be required.

There are no limitations on the number of pacemakers or joint replacement hardware a Member can receive in a Plan year, but each replacement must be Medically Necessary. You are required to pay the applicable Coinsurance with each replacement until you reach your Out-of-pocket maximum.

One-month rental of a wheelchair is Covered if you owned the wheelchair that is being repaired.

Medically Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics

This plan provides coverage for initial and secondary prosthetics devices and custom orthotics in a non-discriminatory manner, and without restriction based on predetermined utilization limits, at the same level and cost-sharing as the coverage provided for medical and surgical benefits. Prosthetic and custom orthotic devices are considered habilitative and rehabilitative essential health benefits and are not subject to separate financial requirements or utilization restrictions. Coverage includes:

- Clinical care.
- All supplies, materials, and devices determined by the physician to be medically necessary and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such as but not limited to running, biking, swimming, strength training.
- All services, including design, fabrication, and repair.
- Replacement, without regard to reasonable useful lifetime restrictions, including replacement necessary due to a change in the patient's condition or the condition of the

device if replacement the device required repairs costing more than 60 percent of replacement cost.

- Access to prosthetic and custom orthotic devices from at least two distinct device providers in your network.

Utilization management decisions related to coverage for prosthetic or custom orthotic devices will be applied in a non-discriminatory manner using the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Prosthetic and custom orthotic benefits will not be denied for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same daily functions and physical activity. However, coverage for prosthetic devised and custom orthotics will not be provided when required solely for comfort or convenience.

Surgical Dressing

Surgical dressings that require a Practitioner's/Provider's prescription, and cannot be purchased over-the-counter, are Covered when Medically Necessary for the treatment of a wound caused by, or treated by, a surgical procedure.

Gradient compression stockings are Covered for:

- Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation.
- Venous stasis ulcers that have been treated by a Practitioner/Provider or other Healthcare Professional requiring Medically Necessary debridement (wound cleaning).

Lymphedema wraps and garments prescribed under the direction of a lymphedema therapist are Covered.

Eyeglasses and Contact Lenses (Limited)

The following will only be Covered:

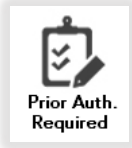
- Contact lenses are Covered for the correction of aphakia (those with no lens in the eye) or keratoconus. This includes the Eye Refraction examination.
- One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is Covered within 12 months after cataract surgery or when related to Genetic Inborn Error of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.

Hearing Aids

Hearing Aids and the evaluation for the fitting of Hearing Aids are Covered every 36 months per hearing impaired ear. This shall include the fitting and dispensing services, including ear molds

as necessary to maintain optimal fit, as provided by an In-network Practitioner/Provider licensed in New Mexico.

Electroconvulsive Therapy (ECT)

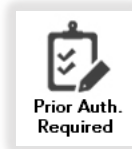


Electroconvulsive Therapy (ECT) requires **Prior Authorization**.

Employee Assistance Program (EAP)

As a Presbyterian Insurance Company Member, you and your enrolled dependents have access to an Employee Assistance Program (EAP). EAP services include up to three employee assistance visits per issue. They are provided by local licensed professionals at The Solutions Group, a division of Presbyterian Healthcare Services. These services are short-term, confidential counseling sessions and can include mediation services, Substance Use Disorder assessments/referrals and other services. Please contact The Solutions Group at **1-866-254-3555** or **(505) 254-3555** if you have any questions regarding EAP covered services and benefits.

Epidural Injections for Back Pain



Epidural corticosteroid injections are utilized in the treatment of disc-related diseases. Epidural injections for back pain require **Prior Authorization**.

Family, Infant and Toddler (FIT) Program



Coverage for children, from birth up to age three under the Family, Infant and Toddler Program (FIT) administered by the Department of Health, provided eligibility criteria are met, is provided for Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel in accordance with state law. Benefits used under this Section will not be applied to your Annual Contract Year Deductible or Annual Out-of-Pocket Maximum.

Genetic Inborn Errors of Metabolism Disorders (IEM)



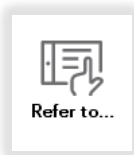
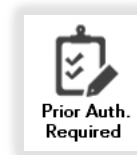
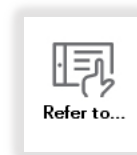
This benefit has one or more exclusions as specified in the Exclusions Section.



Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the **Limitations, Exclusions, and Prior Authorization** requirements listed in this Plan. Medical services provided by licensed Healthcare Professionals, including Practitioners/Providers, dietitians and nutritionists with specific training in managing Members diagnosed with IEM are Covered.

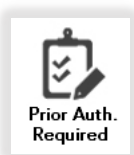
Covered Services include:

- Nutritional and medical assessment
- Newborn Screening for Metabolic Diseases.
- Clinical services
- Biochemical analysis
- Medical supplies
- Prescription Drugs/Medications – Refer to **Prescription Drugs/Medications Section**
- Corrective lenses for conditions related to Genetic Inborn Errors of Metabolism
- Nutritional management
- Special Medical Foods are dietary items that are specially processed and prepared to use in the treatment of Genetic Inborn Errors of Metabolism to compensate for the metabolic abnormality and to maintain adequate nutritional status when we approve the **Prior Authorization** request and when provided under the on-going direction of a qualified and licensed healthcare Practitioner/Provider team. This does not include coverage of nutritional items/food supplements that are available over-the-counter and/or without prescription.
- One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is Covered within 12 months after cataract surgery or when related to Genetic Inborn Error of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.



Refer to **If your child needs dental or eye care in your Summary of Benefits and Coverage** for applicable Cost-Sharing amounts (office visit Copayments, Inpatient Hospital, outpatient facility, Prescription Drug/Medications and other related Deductibles, Coinsurance and/or Copayments).

Genetic/Genomic Testing



Genetic/genomic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Genetic testing is not used as a screening test. Accordingly, a test to determine whether an individual has a BRCA1 or BRCA2 variant is a

genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. Genetic testing requires Prior Authorization.

Gym Membership

As a Presbyterian Insurance Company Member, you and your enrolled dependents (age 18 and older) have access to a designated list of participating national, regional and local fitness, recreation, and community centers.

Participating fitness facilities are subject to change. Presbyterian is not responsible for ensuring certain facilities remain part of the participating network.

Habilitative Services

Habilitative Services are healthcare services that help you keep, learn, or improve skills and functioning for daily living. These services are Covered and may require **Prior Authorization**. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Autism Spectrum Disorder

The diagnosis and treatment for Autism Spectrum Disorder is covered regardless of age in accordance with state mandated benefits as follows:

- Diagnosis for the presence of Autism Spectrum Disorder when performed during a Well-Child or well-baby screening;
- Diagnosis of autism; and
- Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis (ABA) to develop, maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative in nature.

Autism Spectrum Disorder Services must be provided by Practitioners/Providers who are certified, registered or licensed to provide these services.



Limitation – Services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children **3 to 22 years** of age who have Autism Spectrum Disorder are not Covered under this Plan.

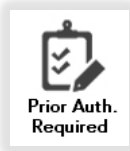
Heart Artery Calcification Scan

Heart Artery calcification scans are a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function. These scans are Covered for individuals between the ages of **45-65 years** and that have an intermediate risk of developing coronary heart disease as determined by a healthcare provider based upon a score calculated from an evidence-based algorithm widely used in the medical community to assess a person's 10-year cardiovascular disease risk, including a score calculated using a pool cohort equation. The scans are Covered only once every five years if an eligible member has previously received a heart artery calcium score of zero. Coverage will not be provided for future heart artery calcium scans if an eligible member receives a heart artery calcium score greater than zero. Heart Artery Calcification Scan is a Covered Preventive benefit with no member Cost Sharing.

Home Health Care Services/Home Intravenous Services and Supplies



This benefit has one or more exclusions as specified in the **Exclusions Section**.



Home Health Care Services are Healthcare Services provided to you when you are confined to the home due to physical illness. Home Health Care Services requires **Prior Authorization** and your Practitioner's/Provider's approved plan of care.

Any Practitioner's/Provider's prescription and **Prior Authorization** must be renewed at the end of each **60-day** period. We will not impose a limitation on the number of related hours per visit.

Home Health Care Services shall include Medically Necessary skilled intermittent Healthcare Services provided by a registered nurse or a licensed practical nurse; physical, occupational, and/or respiratory therapist and/or speech pathologist. Intermittent Home Health aide services are only Covered when part of an approved plan of care which includes skilled services. Such services may include collection of specimens to be submitted to an approved laboratory facility for analysis.

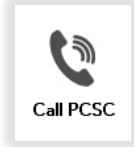
Medical equipment, Prescription Drugs and Medications, laboratory services and supplies deemed Medically Necessary by a Practitioner/Provider for the provision of health services in the home, except Durable Medical Equipment, will be Covered.

The following Home Health Care Services will be Covered when we approve a **Prior Authorization** request:

- Home healthcare or home intravenous services as an alternative to Hospitalization, as determined by your Practitioner/Provider
- Total parenteral and enteral nutrition as the sole source of nutrition
- Medical Drugs (Medications obtained through the medical benefit): A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the

member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization**, and some must be obtained through the specialty network.

- For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our In-network Specialty network, please see the Presbyterian Pharmacy website at <https://www.phs.org/doctors-services/supporting-services/pharmacy-services>.
- You may call our Presbyterian Customer Service Center for more information at **(505) 923-6980** or **1-800-923-6980** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

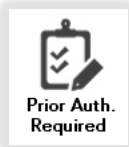


Hospital Services – Inpatient



This benefit has one or more exclusions as specified in the **Exclusions Section**.

Inpatient means you have been admitted by a healthcare Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services are acute care services provided when you are a registered bed patient and there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital.

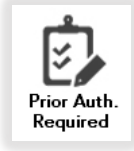


Hospital admissions (Inpatient, non-emergent) require **Prior Authorization**.

Inpatient hospital services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by the covered person's primary care practitioner or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary.

Inpatient Hospital benefits also include Acute Medical Detoxification.

Hyperbaric Oxygen Therapy



Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of The Undersea and Hyperbaric Medical Society (UHMS), or as Medically Necessary. Hyperbaric Oxygen Therapy is **Excluded** for any other condition. Hyperbaric Oxygen Therapy requires **Prior Authorization** when provided by an In-network Practitioner/Provider in order to be Covered.

Infertility



This benefit has one or more exclusions as specified in the **Exclusions Section**.

Diagnosis and medically indicated treatments for physical conditions causing infertility.

Mental Health Services and Alcohol and Substance Use Disorder Services



This benefit has one or more exclusions as specified in the **Exclusions Section**.

No Cost Sharing for Behavioral Health Services

Cost Sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, Substance Use Disorders and trauma spectrum disorders. This includes Cost Sharing for Inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all Medications, including brand-name Pharmacy Drugs when generics are unavailable.

Cost Sharing means any Copayment, Coinsurance, Deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

When in-network access to mental health or substance use disorder services are not reasonably available, Presbyterian will provide access to out-of-network services with no cost-sharing obligations.

Mental Health Services

Some mental health services require **Prior Authorization**. The In-network Behavioral Health Practitioners/Providers will be responsible for obtaining **Prior Authorization**, when required. For Out-of-network Services, Members need to contact our Behavioral Health Department to obtain **Prior Authorization**, when required except when requesting emergency services. Mental health services that require **Prior Authorization** are inpatient hospitalization, partial hospitalization, and residential treatment. Please refer to the **Prior Authorization Section** for services that require **Prior Authorization**. For assistance or for questions related to mental health services, you may call our Behavioral Health Department directly at **(505) 923-5470** or **1-800-453-4347**.



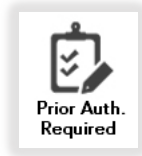
The duration of coverage for an insured with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the insured rather than on arbitrary time limits.

For assistance with accessing or for questions related to mental health services, you may do the following:

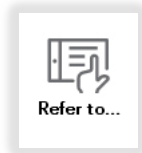
- Schedule an appointment with a behavioral health provider
- Call your Primary Care Practitioner (PCP).
- Call our Behavioral Health Department directly at **(505) 923-5470** or **1-800-453- 4347**.

Partial Hospitalization can be substituted for the Inpatient mental health services when our Behavioral Health Department approves the **Prior Authorization** request. Partial Hospitalization is a non-residential, Hospital-based day program that includes various daily and weekly therapies.

Alcohol and Substance Use Disorder Services



To obtain Alcoholism/Substance Use Disorder services, Members may contact our Behavioral Health Department at **(505) 923-5470** or **1-800-453-4347**. The Behavioral Health Practitioner/Provider will be responsible for any additional **Prior Authorizations**. Inpatient detoxification services require **Prior Authorization** except when requesting emergency services.

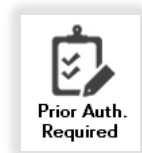


Acute Medical Detoxification Benefits are Covered under Inpatient and Outpatient Medical Services found in the **Benefits Section** of this Plan and will cover no less than **30 days** in an alcohol dependency treatment center and no less than **30 outpatient** visits for alcohol dependency treatment. Some services require **Prior Authorization** except when requesting emergency services. For Out-of-network Services, Members need to contact our Behavioral Health Department in order to obtain **Prior Authorization**, when required. Please refer to the **Prior Authorization Section**.

In all cases, treatment must be Medically Necessary in order to be Covered.

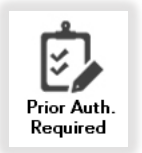
Acute Medical Detoxification Benefits are Covered under Inpatient and Outpatient Hospital Services found in the **Benefits Section** of this Plan and will cover no less than **30 days** in an alcohol dependency treatment center and no less than **30 outpatient** visits for alcohol dependency treatment. Inpatient Hospital Services must receive **Prior Authorization** except for when requesting acute care, initial or emergency services. Presbyterian will not use more restrictive limitations on mental health and substance use disorder benefits than on medical or surgical benefits, including visit limitations, utilization review, or **Prior Authorization**.

Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring Systems



Real-time continuous attended cardiac monitoring systems, such as Mobile Cardiac Outpatient Telemetry™ (MCOT™), are defined as a real-time, outpatient cardiac monitoring system that is automatically activated and requires no patient intervention to either capture or transmit an arrhythmia when it occurs. Mobile cardiac outpatient telemetry and real time continuous attended cardiac monitoring systems require **Prior Authorization**.

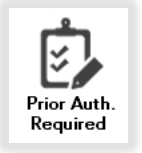
Non-emergency care when traveling outside the U.S.



Non-emergency care when traveling outside the U.S. requires **Prior Authorization**.

Nutritional Support and Supplements

Nutritional counseling when medically necessary and Nutritional Supplements for prenatal care when prescribed by a Practitioner/Provider are Covered for pregnant women.

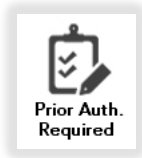


Nutritional supplements that require a prescription to be dispensed are Covered when prescribed by a Practitioner/Provider and when Medically Necessary to replace a specific documented deficiency. **Prior Authorization is required.**

Nutritional supplements administered by injection at the Practitioner's/Provider's office are Covered when Medically Necessary.

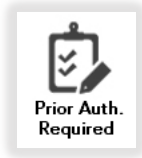
Enteral formulas or products, as Nutritional support, are Covered only when prescribed by an In-network Practitioner/Provider.

Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is Covered when ordered by a Practitioner/Provider.



Special Medical Foods as listed as Covered benefits in the Genetic Inborn Errors of Metabolism (IEM) Benefit of this Section. **Prior Authorization is required.**

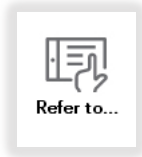
Orthotics



Some prefabricated Orthotics require **Prior Authorization.**

Outpatient Medical Services

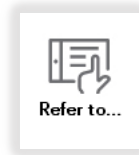
Outpatient Medical Services are services provided in a Hospital, outpatient facility, Practitioner's/Provider's office or other appropriately licensed facility. These services do not require admission to any facility. Outpatient Medical Service facility fees are a covered benefit.



Outpatient Medical services include reasonable Hospital services provided on an ambulatory (outpatient) basis and those diagnostic and treatment procedures that are prescribed by your attending Practitioner/Provider. Refer to the **Prior Authorization Section** for services that require **Prior Authorization.**

Outpatient Medical benefits include, but are not limited to, the following services:

- Chemotherapy and radiation therapy - Chemotherapy is the use of chemical agents in the treatment or control of disease.
- Hypnotherapy (**Limited**) - Hypnotherapy is only Covered when performed by an anesthesiologist or psychiatrist, trained in the use of hypnosis when medically necessary or when:
 - Used within two weeks prior to surgery for chronic pain management and
 - For chronic pain management when part of a coordinated treatment plan.
- Dialysis.
- Diagnostic Services – Refer to the **Diagnostic Services Section.**
- Medical Drugs (Medications obtained through the medical benefit).
 - A Medical Drug is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization**, and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our Specialty network, please see the Presbyterian Pharmacy website at

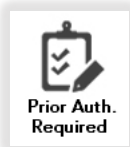


https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739.

These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in the **Prescription Drug Coverage Section** in your *Summary of Benefits and Coverage*.

- Observation following Outpatient Services.
- Sleep disorder studies, in home or outpatient facility (sleep studies done in a facility require **Prior Authorization**).
- Surgery (Some surgeries require **Prior Authorization**).
- Therapeutic and support care services, supplies, appliances, and therapies.
- Wound care.

Positron Emission Tomography (PET) Scans in an Outpatient Setting



Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that quantifies biochemical processes in living tissue. Positron Emission Tomography (PET) scans in an outpatient setting require **Prior Authorization**.

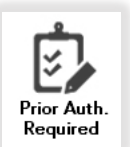
Practitioner/Provider Services



This benefit has one or more exclusions as specified in the **Exclusions Section**.

Practitioner/Provider services are those services that are reasonably required to maintain good health. Practitioner/Provider services include, but are not limited to, periodic examinations and office visits by:

- A licensed Practitioner/Provider, including nurses and physician assistants
- Specialist services provided by other Healthcare Professionals who are licensed to practice, are certified, and practicing as authorized by applicable law or authority
- A medical group
- An independent practice association
- Other authority authorized by applicable state law



Some Practitioner/Provider services require **Prior Authorization**. Refer to the **Prior Authorization Section** for **Prior Authorization** requirements. This Benefit includes, but not limited to, consultation and Healthcare Services and supplies provided by your Practitioner/Provider as shown below:

- Office visits provided by a qualified Practitioner/Provider.
- Presbyterian Health Plan (PHP) Video Visits provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters. PHP Video Visits utilizes a nationwide network of Providers.

- Telehealth appointments through video or phone are with a network Provider, including Presbyterian Medical Group Providers.
- Online visits are an online medical interview followed by a response from a Presbyterian Medical Group Provider.
- Behavioral health services will be provided via telemedicine on the same terms as physical health services in compliance with the telemedicine parity and mental health parity laws.
- Outpatient surgery and Inpatient surgery including necessary anesthesia services. Anesthesia may include hypnotherapy.
- FDA approved contraceptive devices and prescription drugs as described on the drug formulary.
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care.
- Coverage for allergy testing and treatment.
- Sterilization procedures.
- Student Health Centers: Dependent Students attending school either in New Mexico or outside New Mexico may receive care through their PCP or at the Student Health Center. A **Prior Authorization** is not needed prior to receiving care from the Student Health Center. Services provided outside of the Student Health Center are limited to Medically Necessary Covered services for the initial care or treatment of an Emergency Healthcare Service or Urgent Care situation.

Second medical opinions. Cost Sharing will apply when you or your Practitioner/Provider requests the second medical opinion. Cost Sharing will not apply if we require a second medical opinion to evaluate the medical appropriateness of a diagnosis or service.

Prescription Drugs/Medications



This benefit has one or more exclusions as specified in the **Exclusions Section**.

Covered Prescription Drugs/Medication Benefit (Outpatient)

Outpatient Prescription Drugs are a Covered Benefit when prescribed by your Provider. Refer to your *Formulary* for information on the approved Prescription Drugs.

For a complete list of these drugs, please see the Presbyterian Health Insurance Exchange Metal Level *Formulary* list at

<https://client.formularynavigator.com/Search.aspx?siteCode=0324498195>.

Affordable Care Act (ACA)

We will provide Coverage for preventive medications and products as defined by the Affordable Care Act (ACA) if you receive these services from our In-network Practitioners/Providers without cost sharing regardless of sex assigned at birth, gender identity, or gender of the individual.

Preventive medications are used for the management and prevention of complications from conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke.

We will provide Preventive Drugs without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider

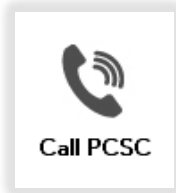
Smoking Cessation Treatments

The following preventive medications and products for smoking cessation treatments are available with no cost sharing: Nicotine gum, Nicotine patches, Nicotine lozenges, Nicotine oral or nasal spray, Nicotine inhaler, bupropion, and Chantix (varenicline).

Visit the *Formulary* listing at

https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739.

Preventive medications will be listed as \$0 Copay per PPACA. For preventive medications (including over-the-counter medications) or products to be Covered, you'll need to get a prescription from your Provider and a pharmacy claim will need to be submitted. Present your ID card to the dispensing pharmacy for processing and billing information. For more information contact our Presbyterian Customer Service Center at **(505) 923-6980** or **1-800-923-6980**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.



Contraception Coverage

You are entitled to receive certain covered contraception services and supplies without Cost Sharing and without prior approval from us. This means that you do not have to make a Copayment, Coinsurance, satisfy a Deductible or pay out-of-pocket for any part of contraception benefits listed in this summary if you receive them from an In-network Provider.

You may be required to pay a copay, coinsurance, and/or a deductible if you receive a contraception service or supply from an out-of-network provider if the same service or supply is available In-network.

Methods of preferred generic oral contraceptives, injectable contraceptives, or contraceptive devices. The oral contraceptives covered by your plan are listed here:

<https://client.formularynavigator.com/Search.aspx?siteCode=0045707827>.

You may also owe Cost Sharing if you receive a brand-name contraceptive when at least one generic or a therapeutic equivalent is available.

Covered Contraceptive Methods

Your plan covers these contraceptive methods:

- Sterilization Surgery for Women
- Sterilization Surgery for Men
- IUD Copper
- IUD with Progestin
- Implantable Rod
- Shot/Injection
- Oral Contraceptives (The Pill) (Combined Pill)
- Oral Contraceptives (Extended/Continuous Use)
- Oral Contraceptives (Mini Pill – Progestin Only)
- Patch
- Vaginal Contraceptive Ring
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Male Condom
- Female Condom
- Spermicide
- Emergency Contraceptive

Long-Acting Reversible Contraceptives

The Long-Acting Reversible Contraceptives (LARCs), including Intrauterine Devices (IUDs) covered without cost-sharing by your plan are listed here:

<https://client.formularynavigator.com/Search.aspx?siteCode=0045707827>. Coverage with no Cost Sharing also applies to IUD insertion and removal, including surgical removal, and to any related medical examination when services are obtained from an In-network provider. Coverage of LARCs with no Cost Sharing also includes (pre-discharge) postpartum clinical services.

Six-Month Dispensing

You are entitled to receive a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. To receive this benefit, your Provider must specifically prescribe the six-month supply. If you need to change your contraceptive method before the six-month supply runs out, you may do so without Cost Sharing. You will not owe Cost Sharing for any related contraceptive counseling or side-effects management.

Brand Name Contraceptives or Devices

Your plan may exclude or apply cost sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Refer to the list of contraceptive categories above. Ask your Provider about a possible equivalent.

If your Provider determines that a brand-name contraceptive is medically necessary, your Provider may ask us to cover that contraceptive without Cost Sharing. If we deny the request, you or your Provider can submit a grievance to contest that denial.

Vasectomies and Male Condoms

This plan covers vasectomies and male condoms. No Prescription or Cost Sharing is required for coverage of male condoms. Please see the section below on Coverage for Contraception Where a Prescription Is Not Required for instructions on reimbursement for condoms.

Sexually Transmitted Infections

Your plan covers contraception methods that are prescribed for the prevention of sexually transmitted infections (STIs). No Cost Sharing applies.

Confidentiality

We require all In-network Practitioners/Providers and facilities to maintain confidential patient information in accordance with federal and state laws including, HIV/AIDS status, mental health, sexually transmitted infections (STIs) or Alcohol/Substance Use Disorder. State and federal law prohibits further disclosure of HIV/AIDS, other STI, mental health and Alcohol Use Disorder and/or Substance Use Disorder information to any person or agency without obtaining specific valid written authorization for that purpose from the patient (or legal guardian/Personal Representative), or as otherwise permitted by state or federal law.

Coverage for Contraception Where a Prescription Is Not Required

Your plan covers contraception with no Cost Sharing even when a Prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this category. You will not have to pay upfront for contraceptives that do not require a Prescription when obtained through an In-network Pharmacy. For all other purchases, you may submit a request for reimbursement as follows:

- Within **90 days** of the date of purchase of the contraceptive method
- Provide the receipt with the item name and amount, your name, address, plan ID number, to the following:

Address: Presbyterian Insurance Company, Inc.
Pharmacy Department
P.O. Box 26267

Albuquerque, NM 87125-6267
Email: askpharmacy@phs.org
Fax: (505) 923-5540

If you submit your complete request for reimbursement electronically or by fax, we will reimburse you within **30 days** of receiving the request. If you submit your complete request for reimbursement by U.S. mail, we will reimburse within **45 days**. Please ensure all information on the reimbursement request is complete to prevent any delays.

Availability of Out-of-Network Coverage

Under your plan, use of an Out-of-network Provider to prescribe or dispense contraceptive coverage is a covered benefit. Please refer to **Out-of-network Care and Bills in the How the Plan Works Section** to learn more about your Out-of-network benefit."

What is a Formulary?

A drug *Formulary*, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgement of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

The primary purpose of the *Formulary* is to encourage the use of safe, effective and most affordable medications. Presbyterian Insurance Company, Inc. administers a closed *Formulary*, which means that Non-*formulary* drugs are not routinely reimbursed by the plan. Medical exception policies provide access to Non-*formulary* medication when Medical Necessity is established.

The medications listed on the *Formulary* are subject to change pursuant to the management activities of Presbyterian Insurance Company, Inc. For the most up-to-date *Formulary* drug information, visit <https://client.formularynavigator.com/Search.aspx?siteCode=0324498195>.

Presbyterian will provide material that contains in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility and **Prior Authorization** requirements, within a reasonable time after enrollment and at subsequent periodic times as appropriate.

Can the Formulary change during the year?

The *Formulary* can change throughout the year. Some reasons why it can change include:

- New drugs are approved.
- Existing drugs are removed from the market.
- Prescription drugs may become available over the counter (without a prescription).
- Brand-name drugs lose patent protection and generic versions become available.
- Changes based on new clinical guidelines.

If we remove drugs from our *Formulary*, add quantity limits, **Prior Authorization**, and/or step therapy restrictions on a drug, or move a drug to a higher Cost-Sharing tier, we must notify affected members of the change at least **60 days** before the change becomes effective.

If your plan provides prescription drug benefits that applies a deductible or coinsurance cost share, Presbyterian will not make any of the following changes to coverage for a prescription drug within 120 days of any previous change to coverage for that prescription drug, unless a generic version of the prescription drug is available.

- Reclassify a drug to a higher tier of the formulary.
- Reclassify a drug from a preferred classification to a non-preferred classification, unless that Reclassification results in the drug moving to a lower tier of the formulary.
- Increase the cost-sharing, copayment, deductible or coinsurance charges for a drug.
- Remove a drug from the formulary.
- Establish a prior authorization requirement.
- Impose or modify a drug's quantity limit; or
- Impose a step-therapy restriction.

How is the Formulary Drug List Developed?

The medications and related products listed on a *Formulary* are determined by a Pharmacy and Therapeutics (P & T) Committee or an equivalent entity. The Presbyterian Insurance Company, Inc., P & T Committee is made up of primary care and specialty physicians, clinical pharmacists and other professionals in the healthcare field.

The P & T Committee meets quarterly to promote the appropriate use of drugs, to maintain the Presbyterian formularies, and to support our network of practitioners. Medications chosen for the *Formulary* are selected based on their safety, effectiveness and overall value. A medication may not be added to the *Formulary* if current drugs on the *Formulary* are equally safe and effective and are less costly. Utilization management strategies such as quality limits, step therapy and **Prior Authorization** criteria are reviewed and approved by the P & T Committee.

Medication coverage criteria is updated and reviewed to reflect current standards of practice. The overall goal of the P & T Committee is to provide a *Formulary* that gives Members access to safe, appropriate, and cost-effective medications that will produce the desired goals of therapy at the most reasonable cost to the member and the healthcare system.

Changes to the Presbyterian *Formulary* are made effective at least **45 days** after the quarterly meeting. If a change to the *Formulary* negatively impacts utilizing members, the members are granted a **60-day** transition period. Members impacted will receive a *Formulary Change* Notification letter with details about the change, the effective date of the change and *Formulary* alternatives if available.

What is Prior Authorization?

Prior Authorization is a clinical evaluation process to determine if the requested Healthcare Service is Medically Necessary, a Covered Benefit, and if it is being delivered in the most appropriate healthcare setting. Our Medical Director or other clinical professional will review the requested Healthcare Service in consultation with your medical provider, and if it meets our requirements for Coverage and Medical Necessity, it is Authorized (approved) before those services are provided.

The **Prior Authorization** process and requirements are regularly reviewed and updated based on various factors including evidence-based practice guidelines, medical trends, Practitioner/Provider participation, state and federal regulations, and our policies and procedures.

- When all necessary information is provided with the Drug Prior Authorization request, standard requests are processed as expeditiously as the member's health requires, within **72 hours** after the request is received.
- When a member or their provider believes that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in jeopardy, a PA can be expedited. These requests are processed within **24 hours** after the request is received.
- Continuation of therapy using any drug is dependent upon its demonstrable efficacy.
- Prior use of free prescription medications (i.e., samples, free goods, etc.) will not be considered in the evaluation of a member's eligibility for medication coverage.

Prescribed drugs will be considered for coverage under the pharmacy benefit when all of the following are met:

- The medication is being prescribed for an FDA approved indication OR the patient has a diagnosis which is considered medically acceptable in the approved compendia* or a peer-reviewed medical journal.
- The patient does not have any contraindications or significant safety concerns with using the prescribed drug.
- If the patient does not meet the above criteria, the prescribed use is considered Experimental or Investigational for Conditions not listed in this section of Evidence of Coverage.
- The approved compendia include:
 - American Hospital *Formulary* Service (AHFS) Compendium.
 - IBM Micromedex Compendium.
 - Elsevier Gold Standard's Clinical Pharmacology Compendium.
 - National Comprehensive Cancer Network Drugs and Biologics Compendium.

What is Step Therapy?

Step Therapy promotes the appropriate use of equally effective but lower-cost *Formulary* drugs first. With this program, prior use of one or more “prerequisite” drugs is required before a step-therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step-therapy drugs.

Presbyterian will not impose step therapy requirements before authorizing coverage for medication approved by the Federal Food and Drug Administration (FDA) that is prescribed for the treatment of a substance use disorder, pursuant to a medical necessity determination, except in cases in which a generic version is available.

What are Quantity Limits?

Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your doctor and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian uses medical guidelines and FDA-approved recommendations from drug makes to set these coverage limits. Quantity limits include the following:

- **Maximum Daily Dose** limits quantities to a maximum number of dosage units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a single day. Limits are based on daily dosages shown to be safe and effective, and that are approved by the Food and Drug Administration (FDA).
- **Quantity Limits over time** limits quantities to number of units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a defined period of time.

Biologic Medications

Biologic medications may be substituted by biosimilar products or by FDA-approved brand medications marketed without the brand on their label (authorized brand alternatives at any time during the contracted coverage year).

Daily Cost Sharing

Daily Cost Sharing reduces the patient pay for the prescription that is less than the standard defined days’ supply. Exclusions may include drug products for acute therapy, unbreakable packages and controlled substances.

Eye Drop Renewal

Renewal of prescription eye drops are allowed by the Plan when the member has utilized 75% of the prescription from the original or last renewal that was dispensed by a network pharmacy.

Insulin for Diabetes Cost-Sharing Cap

The Copayment amount for a preferred *Formulary* prescription insulin drug or a Medically Necessary alternative will be Covered at an amount not to exceed a total of **\$25.00** per **30-day** supply.

Medication Synchronization

Medication Synchronization allows Members to refill all of their Prescriptions on the same day, eliminating the need for multiple trips to the Pharmacy each month. Prescriptions are filled for less than the normal prescribed day supply in order to align the refill date across multiple prescriptions, allowing all refills on the same day and time period. Medication Synchronization is Covered under this Plan.

Orally Administered Anti-Cancer Medications.

This Plan provides coverage for orally administered anti-cancer medication used to slow or kill the growth of cancerous cells. Coverage of these medications are subject to the same Prior Authorization requirements as intravenously administered injected cancer medications Covered by the Plan.

Non-Extended Day Supply

Presbyterian has established protocols under the guidance of National Committee for Quality Assurance (NCQA) in an effort to ensure patients' safety for identified high-risk medications. Pursuant to this guidance, Presbyterian has limited the maximum allowed day supply down to **30 days** at a time for medications that fall into this high-risk category. These drugs are found in the Individual and Family Metal Plans/Employer Group Metal Plans *Formulary* as Non-Extended Day Supplies.

No Behavioral Health Cost Sharing

Formulary Prescription Drugs used for the treatment of mental illness, behavioral health, or Substance Use Disorders when obtained from a behavioral health specialist are covered at no Cost Share. Refer to the *Formulary* listing at <https://client.formularynavigator.com/Search.aspx?siteCode=0324498195> for additional coverage details.

Drug Utilization Review and Drug use evaluation programs

DUR is a review of patient data which is done to evaluate the effectiveness, safety and appropriateness of medication use. These Drug Utilization Review occurs during claim adjudication and determines whether it is likely to cause harm based on interactions with other drugs or based on the member's age, gender, allergies or other drugs on the member's pharmacy profile. The DUR reviews often alert clinicians about prescribing and drug regimen problems and about patients who may be inappropriately taking medications that can produce an undesirable reaction or create other medical complications.

Generic Drugs

The Health Insurance Exchange Metal Level *Formulary* covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Brand-Name Drugs When a Generic Equivalent is Available

A generic equivalent will be dispensed if available. If your prescriber requests to dispense a brand-name drug when a generic equivalent is available, the request will require a Medical Exception.

If Medical Necessity is established, the non-preferred drug copay plus the difference between the brand-name and the generic drug will apply. Otherwise, brand-name drugs dispensed when a generic equivalent is available are not covered and will not count towards the deductible or annual out-of-pocket maximums.

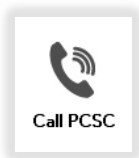
What if my Drug is not Covered?

You or your doctor can ask us to make an exception (**Prior Authorization**) to our coverage rules. We will work with your prescriber to get additional information to support your request.

There are several types of exceptions that you can ask us to make:

- You can ask us to cover your drug even if it is not on our *Formulary*.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- Our review of a prior authorization request will determine if the proposed care involves a covered service, is medically necessary and whether an alternative type of prescription medication should be pursued instead of, or before, the requested prescription medication. Our decisions concerning medical necessity and *Formulary* alternatives will be guided by current clinical guidelines and will be made by an appropriate medical professional. Prior authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

Refer to the **Summary of Health Insurance Grievance Procedures Section** for additional information about the grievance process.



For more information contact our Presbyterian Customer Service Center at **(505) 923-6980** or **1-800-923-6980**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call our **TTY** line at **711**.

Additional information explaining the exception process can be found at <https://client.formularynavigator.com/Search.aspx?siteCode=0324498195>.

Benefit Limitations



This benefit has one or more exclusions as specified in the **Exclusions Section**.

You have the option to purchase up to a **90-day** supply of Prescription Drugs/Medications. Under the up to a **90-day** at Retail Pharmacy benefit, Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Drugs can be obtained from an In-network Pharmacy. If you choose the **90 days** at retail option, you will be charged one copayment per **30-day** supply up to a maximum of a **90-day** supply.



Some medications may qualify for third-party copayment assistance programs which could lower your out-of-pocket costs for those products. For any such medication where third-party copayment assistance is used (Discount Cards or Prescription Drug Savings Cards), the Member will receive credit towards their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

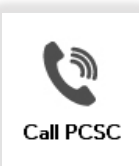
Self-Administered Specialty Pharmaceuticals

Self-Administered Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or care-giver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life-threatening conditions. Specialty Pharmaceuticals are often high cost, typically greater than \$600 for up to a 30-day supply.

- Specialty Pharmaceuticals are not available through the retail or mail order option and are limited to a 30-day supply.
- Certain Specialty Pharmaceuticals may have additional day supply limitations.
- Most Specialty Pharmaceuticals must be obtained through the specialty pharmacy network.

For a complete list of these drugs and formulary coverage, please see the Specialty Pharmaceutical listing at

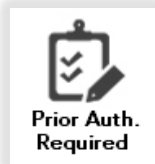
<https://client.formularynavigator.com/Search.aspx?siteCode=0324498195>.



For Specialty Pharmacy information please see the pharmacy services available at <https://www.phs.org/doctors-services/supporting-services/pharmacy-services>. You can call our Presbyterian Customer Service Center for additional information about the Presbyterian Specialty Pharmacy network, Monday through Friday from

7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711**.

Office Administered Specialty Pharmaceuticals (Medical Drug)



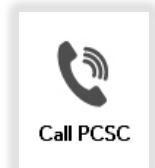
A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization**, and some must be obtained through the specialty network.

These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in the **Prescription Drug Coverage Section** in your *Summary of Benefits and Coverage*.

For a complete list of Medical Drugs to determine which require **Prior Authorization**, please see the Presbyterian Pharmacy website at <https://www.phs.org/doctors-services/supporting-services/pharmacy-services>.

Mail Order Pharmacy

You have a choice of obtaining certain Prescription Drugs/Medications directly from a Pharmacy or by ordering them through the mail. Under the mail order pharmacy benefit, Preferred and non-Preferred medications can be obtained through the Mail Order Service Pharmacy. You may purchase up to a **90-day** supply up to the maximum dosing recommended by the manufacturer. Cost sharing Copayments at the applicable Tier Copayment and certain drugs may not be purchased by mail order, such as Self-Administered Specialty Pharmaceuticals.



You may obtain more information on the Mail Service Pharmacy by calling our Presbyterian Customer Service Center at **(505) 923-6980** or **1-800-923-6980**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Member Reimbursement

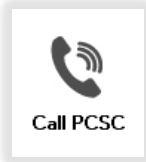
If a medical Emergency occurs and a pharmacy is unable to submit a claim at point of service you may pay for the prescription and request Presbyterian Insurance Company, Inc., to reimburse you. A Pharmacy Specialist will review and process your request for reimbursement based on the negotiated rate between Presbyterian Insurance Company, Inc., and the dispensing pharmacy minus any copay or coinsurance that may apply. Members will not be liable to a provider for any sums owed to the provider by Presbyterian.

The following information is needed to determine reimbursement amounts. Please submit a *Prescription Drug Reimbursement Form* and attach the itemized cash register receipt and the prescription drug detail (pharmacy pamphlet) along with the following information:

- Patient's name

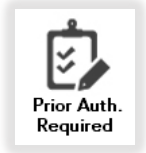
- Patient's Date of Birth
- Name of the drug
- Quantity dispensed
- NDC (National Drug Code)
- Fill Date
- Name of Prescriber
- Name and phone number of the dispensing pharmacy
- Reason for the purchase (nature of emergency)
- Proof of Payment

Please see the Presbyterian Pharmacy website at <https://www.phs.org/doctors-services/supporting-services/pharmacy-services> to obtain a form or call our Presbyterian Customer Service Center at **(505) 923-6980** or **1-800-923-6980**, Monday through Friday from 7 a.m. to 6 p.m. **TTY** users may call **711**. Please follow the mailing instructions on the *Member Reimbursement* form.



A Pharmacy Services Call Center is available 24 hours a day to providers, pharmacies and members to address pharmacy benefit questions. Please contact Presbyterian Customer Service Center at **(505) 923-6980** or **1-800- 923-6980** (follow the voice prompts and select Pharmacy).

Proton Beam Irradiation



Proton beam therapy is a type of radiation therapy that utilizes protons to deliver ionizing damage to a target. Proton Beam Irradiation requires **Prior Authorization**.

Reconstructive Surgery



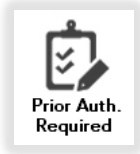
This benefit has one or more exclusions as specified in the **Exclusions Section**.

Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be provided if performed for the correction of functional disorders.

This surgery is covered if performed as medically necessary. The following reconstructive surgery benefits are covered:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery

- Reconstructive surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery
 - For information regarding Reconstructive Surgery following a Mastectomy and Prophylactic Mastectomy, refer to the **Women’s Healthcare Section**.
- Reconstructive surgery related to Gender Confirmatory Therapy and Gender Affirming Care are Covered. The **Prior Authorization** criteria of this Plan is applicable.



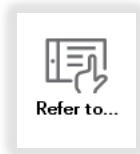
Reconstructive Surgery must be prescribed by a Member’s Practitioner/Provider and requires **Prior Authorization**.

Rehabilitation and Therapy



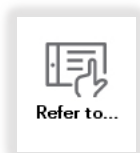
This benefit has one or more exclusions as specified in the **Exclusions Section**.

Cardiac Rehabilitation Services



Cardiac Rehabilitation benefits are available for continuous electrocardiogram (ECG) monitoring, progressive exercises and intermittent ECG monitoring. Refer to Rehabilitation Services in your *Summary of Benefits and Coverage* for your Cost Sharing amount.

Pulmonary Rehabilitation Services

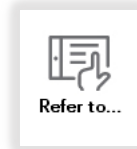


Pulmonary Rehabilitation benefits are available for progressive exercises and monitoring of pulmonary functions. Refer to Rehabilitation Services in your *Summary of Benefits and Coverage* for your Cost Sharing amount.

Short-term Rehabilitation Services

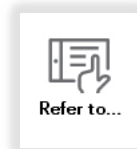
Short-term Rehabilitation benefits are available for physical therapy, occupational therapy, and speech therapy, provided in a Rehabilitation Facility, Skilled Nursing Facility, Home Health Agency, or Outpatient setting. Short-term Rehabilitation is designed to assist you in restoring functions that were lost or diminished due to a specific episode of illness or injury (for example, stroke, motor vehicle accident, or heart attack). Coverage is subject to the following requirements and **limitations**:

- Voice training related to Gender Confirmatory Therapy and Gender Affirming Care is a Covered benefit and may be subject to **Prior Authorization**.
- Presbyterian will not impose a member cost share for physical rehabilitation & Chiropractic services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applicable or if a copay is applicable. The physical rehabilitation services must be performed by, or under the direction of a licensed physical therapist, occupational therapist or speech therapist. The Chiropractic services must be performed by a Chiropractic physician.
- Outpatient physical and occupational therapy require that your Practitioner/Provider must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in your condition. Refer to Rehabilitation and Habilitation Services in your *Summary of Benefits and Coverage* for your Cost Sharing amounts.
- The treatment plans that define expected Significant Improvement must be established at the initial visit. Therapy treatments must be provided and/or directed by a licensed physical or occupational therapist.
- Massage Therapy is only Covered when provided by a licensed physical therapist and as part of a prescribed Short-term Rehabilitation physical therapy program. Refer to Rehabilitation and Habilitation in your *Summary of Benefits and Coverage* for your Cost Sharing amount.
- Outpatient Speech therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Speech therapy is Covered when provided by a licensed or certified speech therapist.



Coverage is subject to the following **limitations**:

- Your Practitioner/Provider must determine, in advance, in consultation with us, that speech therapy can be expected to result in Significant Improvement in your condition. Refer to Rehabilitation and Habilitation Services in your *Summary of Benefits and Coverage* for your visit limitations and Cost Sharing amounts.



If your Short-Term Rehabilitation therapy is provided in an Inpatient setting (such as, but not limited to, Rehabilitation Facilities, Skilled Nursing Facilities, intensive day-Hospital programs that are delivered by a Rehabilitation Facility) or through Home Health Care Services, the therapy is not subject to time limitation requirements of the Outpatient therapies outlined in your *Summary of Benefits and Coverage*. These Inpatient and Home Health therapies are not included with Outpatient services when calculating the total accumulated benefit usage.

Selected Surgical/Diagnostic Procedures

Presbyterian also covers surgical/diagnostic procedures, which may be subject to **Prior Authorization**:

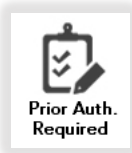
- Bariatric Surgery
- Blepharoplasty/Brow Ptosis Surgery

- Breast Reconstruction following mastectomy
- Breast reduction for gynecomastia
- Endoscopy Nasal/Sinus balloon dilation
- Gender Confirmation Surgery
- Hysterectomy
- Lumbar/Cervical Spine Surgery
- Major endoscopic procedures
- Meniscus Implant and Allograft/Meniscus Transplant
- Operative and cutting procedures
- Panniculectomy
- Preoperative and postoperative care
- Rhinoplasty
- Tonsillectomy
- Total Ankle Replacement
- Total Hip Replacement
- Total Knee Replacement
- Varicose Vein Procedures

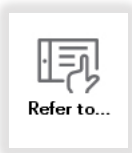
Skilled Nursing Facility Care



This benefit has one or more exclusions as specified in the **Exclusions Section**.



Room and board and other necessary services furnished by a Skilled Nursing Facility are Covered and require **Prior Authorization**. Admission must be appropriate for your Medically Necessary care and rehabilitation.



Refer to Skilled Nursing in your *Summary of Benefits and Coverage* for your visit limitations.

Smoking Cessation Counseling/Program

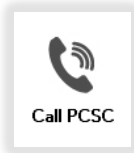


This benefit has one or more exclusions as specified in the **Exclusions Section**.

Coverage is provided for Diagnostic Services, Smoking Cessation Counseling and pharmacotherapy. Medical services are provided by licensed Healthcare Professionals with

specific training in managing your Smoking Cessation Program. The program is described as follows:

- Individual counseling at a Practitioner’s/Provider’s office is Covered under the medical benefit. The non-specialist Copayment applies.
- Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Practitioner/Provider. No Cost Sharing will apply and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. You may want to utilize these services.

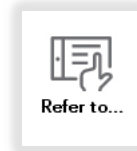


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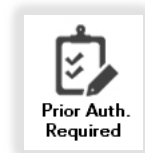
Pharmacotherapy benefit Limitations

- Prescription Drugs/Medications purchased at a Pharmacy
- Two **90-day** courses of treatment per Contract Year

Refer to Prescription Drug Coverage in your *Summary of Benefits and Coverage* and your *Formulary* for your Cost Sharing amount.



Special Inpatient Services



Special inpatient services (including but not limited to private room and board and/or special duty nursing requires **Prior Authorization**).

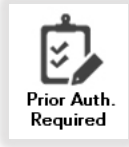
Telemedicine Services

Presbyterian Insurance Company (PIC) provides coverage for telemedicine services to the same extent that this Plan covers the same services when provided in-person or In-network. PIC will not impose originating-site restrictions. Coverage may be extended to Out-of-network Providers in instances where no In-network Provider is accessible, as defined by network adequacy standards. A determination by PIC that services delivered through the use of telemedicine are not Covered is subject to review and appeal.

Transplants



This benefit has one or more exclusions as specified in the **Exclusions Section**.



All Organ transplants must be performed at an approved center and require **Prior Authorization**.

Presbyterian provides coverage for organ transplantation and associated care and will not:

- deny that coverage solely on the basis of a covered person's physical or mental disability;
- deny to a covered person with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit policy or plan solely for the purpose of avoiding the requirements of this section;
- penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care provider to induce that health care provider not to provide an organ transplant or associated care to a covered person with a physical or mental disability; or
- reduce or limit coverage benefits to a covered person with a physical or mental disability for the associated care related to organ transplantation as determined in consultation with the physician and patient.

Human Solid Organ transplant benefits are Covered for:

- Kidney
- Liver
- Pancreas
- Intestine
- Heart
- Lung
- Multi-visceral (3 or more abdominal Organs)
- Simultaneous multi-Organ transplants – unless investigational
- Pancreas islet cell infusion
- Meniscal Allograft
- Autologous Chondrocyte Implantation – knee only
- Hematopoietic Transplant Benefits are Covered for:
 - Bone Marrow Transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are Covered for the following indications:
 - Multiple myeloma
 - Leukemia

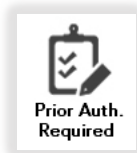
- Aplastic anemia
- Lymphoma
- Severe combined immunodeficiency disease (SCID)
- Wiskott Aldrich syndrome
- Ewing's Sarcoma
- Germ cell tumor
- Neuroblastoma
- Wilms Tumor
- Myelodysplastic Syndrome
- Myelofibrosis
- Sickle cell disease
- Thalassemia major

If there is a living donor that requires surgery to make an Organ available for a Covered transplant for our Member, Coverage is available for expenses incurred by the living donor for surgery, laboratory and X-ray services, Organ storage expenses, and Inpatient follow-up care only. We will pay the Total Allowable Charges for a living donor who is not entitled to benefits under any other health benefit plan or policy.



Limited travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be Covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be Covered for both out-of-state and instate, up to a maximum of **\$150** per day for the transplant recipient, live donor and one other person combined. Organ transplants must be performed at a site that we approve and require **Prior Authorization**.

Wireless Capsule Endoscopy

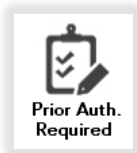


Wireless capsule endoscopy is a noninvasive procedure in which a capsule containing a miniature video camera is swallowed. Capsule endoscopy is used as an adjunctive therapy in patients who have had an esophagogastroduodenoscopy (EGD) or colonoscopy, and these tests have failed to reveal evidence of disease or a source of bleeding. This procedure requires **Prior Authorization**.

Women's Healthcare



This benefit has one or more exclusions as specified in the Exclusions Section.



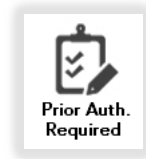
The following Woman's Healthcare Services, in addition to services listed in the **Preventive Care Section** are available for our female Members under the Women's Health and Cancer Rights Act (WHCRA). Inpatient Hospital services require **Prior Authorization**.

Obstetrical/Gynecological care includes:

- Annual exams
- Care related to pregnancy
- Miscarriage
- Therapeutic abortions
- Elective abortions up to 24 weeks
- Other obstetrical/gynecological services

Prenatal Maternity care benefits include:

- Prenatal care
- Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus)
- Visits to an Obstetrician
- Certified Nurse-midwife
- Licensed Midwife
- Medically Necessary nutritional supplements as determined and prescribed by the attending Practitioner/Provider. Prescription nutritional supplements require **Prior Authorization**.
- Childbirth in a Hospital or in a licensed birthing center

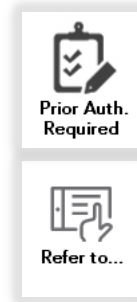


Maternity Care

In Accordance with the Newborns' and Mothers' Health Protection Act (the Newborns' Act), the following benefits are Covered:

- Maternity Coverage is available to a mother and her newborn (if a Member) for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a cesarean section. Maternity In-patient Hospital admissions and birthing center admissions require notification to appropriately manage care. Your provider will provide notification to the Health Plan of your maternity admission. Please see coverage for emergent/**Prior Authorization** admissions.
- In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her attending Practitioner/Provider. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists including, but not limited to, the criterion that family Members or other support person(s) will be available to the mother for the first few days following early discharge.

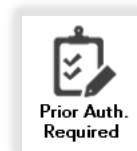
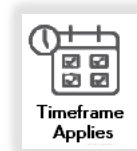
- Maternity Inpatient care in excess of **48 hours** following a vaginal delivery and **96 hours** following a cesarean section will be Covered if determined to be Medically Necessary by the mother's attending Practitioner/Provider. An additional stay will be considered a separate Hospital stay and requires **Prior Authorization**. Refer to If you are pregnant in your *Summary of Benefits and Coverage* for Cost Sharing information.
- High-risk Ambulance services are Covered in accordance with the **Ambulance Services Benefits Section**.
- The services of a Licensed Midwife or Certified Nurse Midwife are Covered, for the following:
 - The midwife's services must be provided strictly according to their legal scope of practice and in accordance with all applicable state licensing regulations which may include a supervisory component.
 - The services must be provided in preparation for or in connection with the delivery of a newborn.
 - For purpose of Coverage under this Plan, the only allowable sites of delivery are a Hospital or a licensed birthing center. Elective Home Births and any prenatal or postpartum services connected with Elective Home Births are not Covered. Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.



Newborn Care

A newborn of a Member will be Covered from the moment of birth when enrolled as follows:

- We must receive the signed and completed enrollment Application for the newborn that was submitted to the employer Group within **31 days** from the date of birth.
- If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed enrollment Application within the first **31 days** following the date of birth.
- If the above conditions are not met, we will not enroll the newborn for Coverage until the next Annual Group Enrollment Period.
- Neonatal care is available for the newborn of a Member for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a Cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, it is considered a separate Hospital stay and requires **Prior Authorization**. Refer to If you are pregnant in your *Summary of Benefits and Coverage* for your Cost Sharing amount.
- Benefits for a newborn who is a Member shall include Coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Where necessary to protect the life of the infant Coverage includes transportation, including air Ambulance Services to the nearest available Tertiary facility. Newborn Member benefits also include



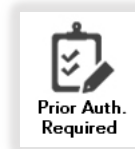
Coverage for newborn visits in the Hospital by the baby's Practitioner/Provider, circumcision, incubator, and routine Hospital nursery charges.

- A newborn of a Member's Dependent child **cannot** be enrolled unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by the court as the newborn's legal guardian.

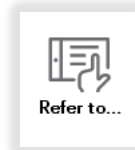
Additional Women's Healthcare Benefits

- Mammography and Diagnostic Mammography Coverage.
- Mastectomy, Prophylactic Mastectomy, Prosthetic Devices, Prophylactic Oophorectomy, Risk Reduction Surgery, and Reconstructive surgery.

Some care requires **Prior Authorization**.



- Coverage for Medically Necessary surgical removal of the breast (mastectomy) is for not less than **48 hours** of Inpatient care following a mastectomy and not less than **24 hours** of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless you and the attending Practitioner/Provider determine that a shorter period of Hospital stay is appropriate.
- Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer is subject to Cost Sharing amounts consistent with those imposed on other benefits. Refer to If you have a hospital stay in your *Summary of Benefits and Coverage* for Cost Sharing amounts.
- Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). Two bras per year are Covered for Members with external breast prosthesis.
- As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.
- Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy.



- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- The Alpha-fetoprotein IV screening test for pregnant women, generally between 16 and 20 weeks for pregnancy, to screen for certain genetic abnormalities in the fetus.
- Non-Invasive Prenatal Testing (NIPT)
- Coverage for the preventive screening of women who have family members with breast, ovarian, tubal or peritoneal cancers with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2) (may require **Prior Authorization**).
- Women with positive screening results may receive genetic counseling and, if indicated after counseling, BRCA testing as determined by her healthcare provider (may require **Prior Authorization**).

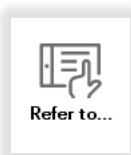
General Limitations

This Section explains the general limitations that apply to your Covered Benefits and other Sections of this Plan.

Benefit Limitations

Your Covered Benefits may have specific **limitations** or requirements and are listed under the specific benefit section of this document:

- Some Benefits may be subject to dollar amount and/or visit **limitations**.
- Benefits may be excluded if the services are provided by Out-of-network Practitioners/Providers.
- Some Benefits may be subject to **Prior Authorization**.



Refer to Limitations, Exceptions & Other Important Information in your *Summary of Benefits and Coverage* and the **Benefits Section** for details about these limitations.

Major Disasters

In the event of any major disaster, epidemic or other circumstances beyond our control, we shall render or attempt to arrange Covered Benefits with In-network Practitioners/Providers insofar as practical, according to our best judgment, and within the limitations of facilities and personnel as are then available. However, no liability or obligation shall result from nor shall be incurred for the delay or failure to provide any such service due to the lack of available facilities or personnel if such lack is the result of such disaster, epidemic or other circumstances beyond our control, and if we have made a good-faith effort to provide or arrange for the provision of such services. Such circumstances include complete or partial disruption of facilities, war, act(s) of terrorism, riot, civil insurrection, disability of a significant part of a Hospital, our personnel or In-network Practitioners/Providers or similar causes. This provision does not impose any limitation on the availability of Coverage for services provided by Out-of-network Practitioners/Providers.

Presbyterian Insurance Company (PIC) Continuation

If you are Covered by our continuation policy and are also Covered by another group medical plan you shall receive our benefits to the extent that we are the secondary payer of all eligible charges, subject to the terms, conditions and limitations of this Plan.

Prior Authorization

Benefits for certain services and supplies are subject to **Prior Authorization** as specified in the **Prior Authorization Section**. Benefits may not be payable for services from Out-of-network Practitioners/Providers if you fail to obtain **Prior Authorization**.

Exclusions

This Section lists services that are not Covered (Excluded Services) under your Health Benefit Plan. All other benefits and services not specifically listed as Covered in the Benefits Section shall be Excluded Services except as required by state or federal law.

Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be not Medically Necessary when subject to medical necessity review, is not Covered. This includes any service, which is not recognized according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the Healthcare Insurer consistent with such federal, national, and professional practice guidelines, or any service for which the required approval of a government agency has not been granted at the time the service is provided.

Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services, and Observation Services

Emergency Healthcare Services – Use of an emergency facility for non-emergent services is not Covered. This does not include situations in which a covered person, acting in good faith and possessing an average knowledge of health and medicine, visits the emergency room for what appears to be an acute condition that requires immediate medical attention.

Ambulance Services

Ambulance service (ground or air) to the coroner's office or to a mortuary is not Covered, unless the Ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.

Autopsies

Autopsy costs for Covered Members are not Covered.

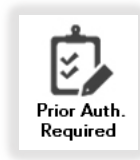
Before or After the Effective Date of Coverage

Services received, items purchased, prescriptions filled or healthcare expenses incurred before your effective date of Coverage or after the termination of your Coverage are not Covered.

Clinical Trials

Any Clinical Trials provided outside of New Mexico, as well as those that do not meet the requirements indicated in the Benefits Section, are not Covered.

Costs of the Clinical Trial that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources are not Covered.



Services from Out-of-network Practitioners/Providers, unless services from an In-network Practitioner/Provider is not available and are not Covered. **Prior Authorization** is required for any Out-of-network Services and such services must be provided for in New Mexico. Prior Authorization is not required for Emergent or Urgent Care Services In- or Out-side of New Mexico.

The cost of a non-FDA approved Investigational drug, device or procedure is not Covered.

The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Clinical Trial is not Covered.

Costs associated with managing the research that is associated with the Clinical Trials are not Covered.

Costs that would not be Covered if non-Investigational treatments were provided are not Covered.

Costs of tests that are necessary for the research of the Clinical Trial are not Covered.

Costs paid for or not charged by the Clinical Trial Providers are not Covered.

If you are denied coverage of a cost and you contend that the denial is in violation of NMSA 1978 59A-22-43, you may appeal the decision to deny the coverage of a cost to the superintendent, and that appeal shall be expedited to ensure resolution of the appeal within no more than **30 days** after the date of appeal to the superintendent.

Care for Military Service-Connected Disabilities

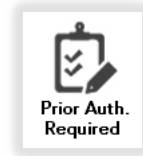
Care for military service-connected disabilities to which you are legally entitled and for which facilities are reasonably available to you is not Covered.

Certified Hospice Care Benefits

Certified Hospice Care Benefits are not Covered for the following services:

- Food, housing, and delivered meals are not Covered.
- Volunteer services are not Covered.
- Personal or comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits) are not Covered.
- Homemaker and housekeeping services are not Covered.
- Private duty nursing is not Covered.
- Pastoral and spiritual counseling are not Covered.

- Bereavement counseling is not Covered.
- The following services are not Covered under Hospice care, but may be **Covered Benefits elsewhere in this Plan** subject to the Cost Sharing requirements:
 - Acute Inpatient Hospital care for curative services – requires **Prior Authorization**
 - Durable Medical Equipment
 - Practitioner/Provider visits by other than a Certified Hospice Practitioner/Provider
 - Ambulance Services



Charges in Excess of Medicare Allowable Unreasonable

Charges that we determine to be in excess of Medicare Allowable and charges we determine to be unreasonable based on usual, customary, and reasonable charges are not Covered.

Clothing or Other Protective Devices

Clothing or other protective devices, including prescribed photo-protective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not, are not Covered.

Clinical Preventive Health Services

Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to employment are not Covered.

Immunizations for the purpose of foreign travel are not Covered.

Complementary Therapies

Complementary Therapies, except those specified in the **Complementary Therapies Benefits Section**, are not Covered.

- **Acupuncture** – Except as specified under Complementary Therapies in the Benefits Section.
- **Chiropractic Services** – Except as specified under Complementary Therapies in the Benefits Section.
- **Biofeedback** – Except as specified under Complementary Therapies in the Benefits Section.

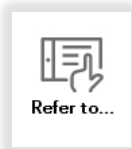
Cosmetic Surgery

Cosmetic Surgery is not Covered. Examples of Cosmetic Surgery that are not Covered include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery

(including cryotherapy), asymptomatic keloid/scar revision, micro phlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.

This plan does not cover cosmetic surgery, services, or procedures to change family characteristics or conditions caused by aging. This plan excludes coverage for cosmetic surgery or services for psychiatric or psychological reason unrelated to care for gender dysphoria and Medically Necessary gender confirmation care. This plan does not cover services related to or required as a result of a cosmetic service, procedure, surgery or subsequent procedures to correct unsatisfactory Cosmetic results attained during an initial surgery.

Circumcisions, performed other than for newborns, are not Covered unless Medically Necessary.



Reconstructive Surgery following a mastectomy is not considered Cosmetic Surgery and will be covered. Refer to the **Benefits Section**.

Cosmetic Treatments, Devices, Orthotics, and Prescription Drugs/Medications

Cosmetic treatment, devices, Orthotics and Prescription Drugs/Medications are not Covered.

Costs for Extended Warranties and Premiums for Other Insurance Coverage

Costs for extended warranties and premiums for other insurance coverage are not Covered.

Dental Services

Dental care and dental X-rays are not Covered, except as provided in the Benefits Section.

Dental implants are not Covered.

Malocclusion treatment, if part of routine dental care and orthodontics, is not Covered.

Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are not Covered, unless the disorder is trauma related.

Diabetes Services

Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses is not Covered, unless Medically Necessary due to diabetes or other significant peripheral neuropathies. Coverage of diabetes services requires medical diagnosis of diabetes from a licensed practitioner/provider. Equipment, appliances, prescription drug. Medications, insulin or supplies must have FDA approval and are the medically accepted standards for diabetes treatment, supplies, and education.

Coverage for Diabetes Education must be:

- Medically necessary, or
- Due to a significant change in condition or symptoms, or
- When re-education is prescribed by a practitioner/provider, or
- Telephonic visits with a certified diabetes educator (CDE) that are part of our In-network Practitioners/Providers who are registered, certified or licensed healthcare professional with recent education in diabetes management; or
- Related to medical nutrition therapy.

Diabetes supplies and services:

- Must use approved brands
- Must be purchased at In-network pharmacy, preferred vendor or preferred durable medical equipment (DME) supplier
- Insulin pumps are covered only when medically necessary and when prescribed by an In-network endocrinologist
- Podiatric appliances for prevention of foot complications associated with diabetes must be medically necessary
- Must use preferred prescriptive diabetic oral agents, insulin, blood glucose monitors/meters, test strips for blood glucose monitors, and lancets and lancet devices according to the *Formulary*

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids

Durable Medical Equipment

Upgraded or deluxe Durable Medical Equipment is not Covered.

Convenience items are not Covered. These include, but are not limited to, an appliance, device, object or service that is for comfort and ease and is not primarily medical in nature, such as, shower or tub stools/chairs, seats, bath grab bars, shower heads, hot tubs/Jacuzzis, vaporizers, accessories such as baskets, trays, seat or shades for wheelchairs, walkers and strollers, clothing, pillows, fans, humidifiers, and special beds and chairs (excluding those Covered under Durable Medical Equipment Benefits).

Duplicate Durable Medical Equipment items (i.e., for home and office) are not Covered.

Repair and Replacement

Repair or replacement of Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience is not Covered.

Repair and replacement of items under the manufacturer or supplier's warranty are not Covered.

Additional wheelchairs are not Covered, if the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair.

Orthotic Appliances

Functional foot Orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints are not Covered, except for patients with diabetes or other significant peripheral neuropathies.

Custom-fitted Orthotics/Orthosis are not Covered except for knee-ankle-foot (KAFO) Orthosis and/or ankle-foot Orthosis (AFO) except for Members who meet national recognized guidelines.

Prosthetic Devices

Artificial aids including speech synthesis devices are not Covered, except items identified as being Covered in the **Benefits Section**.

Surgical Dressing

Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, adhesive bandages, gauze (such as four inches by four inches), and elastic wrap bandages are not Covered, except when provided in a Hospital or Practitioner's/Provider's office or by a home health professional.

Gloves are not Covered, unless part of a wound treatment kit.

Elastic Support hose are not Covered.

Eyeglasses and Contact Lenses

Routine vision care and Eye Refractions for determining prescriptions for corrective lenses are not Covered, except as identified in the **Benefits Section**.

Corrective eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, are not Covered except as identified in the **Benefits Section**.

Eye refractive procedures including radial keratotomy, laser procedures, and other techniques are not Covered.

Visual training is not Covered.

Eye movement therapy is not Covered.

Exercise Equipment, Personal Trainers, Club Memberships

Exercise equipment, videos, personal trainers, and weight reduction programs are not Covered.

Experimental or Investigational drugs, Diagnostic Genetic Testing, Medicines, Treatments, Procedures, or Devices

Experimental or **Investigational** drugs, diagnostic genetic testing, medicines, treatments, procedures, or devices are not Covered.

Experimental or Investigational medical, surgical, diagnostic genetic testing, other healthcare procedures or treatments, including drugs. As used in this Plan, “Experimental” or “Investigational” as related to drugs, devices, medical treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by state law, the drug or device is used for a purpose that is not approved by the FDA; or
- For the purposes of this section, “reliable evidence” shall mean only published reports and articles in the authoritative medical and scientific literature listed in state law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, “Experimental” or “Investigational” does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

Extracorporeal Shock Wave Therapy

Extracorporeal shock wave therapy involving the musculoskeletal system is not Covered.

Foot Care

Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses, is not Covered, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.

Genetic Testing

Genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Accordingly, a test to determine whether an individual has a BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder if that person has a known family history or classic symptoms of a disorder. Genetic testing is not covered when the test is performed primarily for the medical management of other family members. Additional expenses for banking of genetic material are not covered.

Genetic Inborn Errors of Metabolism Coverage

Genetic Inborn Errors of Metabolism Coverage does not include the following items:

- Food substitutes for lactose intolerance or other carbohydrate intolerances, including soy foods or elemental formulas or other Over-the-counter (OTC) digestive aids are not Covered, unless listed as a Covered Over-the-counter (OTC) medication on our *Formulary*.
- Ordinary food that might be part of an exclusionary diet are not Covered.
- Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM are not Covered.
- Special Medical Foods for conditions that are not present at birth are not Covered.
- Dietary supplements and items for conditions including, but not limited to, Diabetes Mellitus, Hypertension, Hyperlipidemia, Obesity, Autism Spectrum Disorder, Celiac Disease and Allergies to food products are not Covered.

Hair-loss (or baldness)

Hair-loss or baldness treatments, medications, supplies and devices, including wigs, and special brushes are not Covered regardless of the medical cause of the hair-loss or baldness.

Home Health Care Services/Home Intravenous Services and Supplies

Private duty nursing is not Covered.

Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify for Home Health Care Services and are not Covered. Examples of Custodial Care that are not Covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

Hospital Services Inpatient

Rehabilitation is not Covered as part of Acute Medical Detoxification.

Infertility

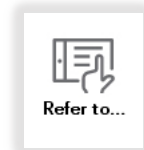
Infertility services, listed below, are not Covered.

- Prescription Drugs and Injections when provided by practitioner/provider.
- Reversal of voluntary sterilization is not Covered.
- Donor sperm is not Covered.
- In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization are not Covered.
- Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue is not Covered.
- Prescription Drugs/Medications used in conjunction with In-vitro fertilization and artificial insemination are not Covered.
- Oral or injectable medications used to promote pregnancy are not Covered.
- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are not Covered.

Mental Health and Alcohol and Substance Use Disorder

Mental Health

- Codependency treatment is not Covered.
- Bereavement, pastoral/spiritual and sexual counseling are not Covered.
- Psychological testing when not Medically Necessary is not Covered.
- Special education, school testing or evaluations, educational counseling, therapy or care for learning deficiencies or disciplinary problems are not Covered. This applies whether or not associated with manifest mental illness or other disturbances except as Covered under the Family, Infant and Toddler Program. Refer to the **Benefits Section**.
- Unless medically necessary, court-ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy is not Covered.



Alcohol Services and Substance Use Disorder Services

- Treatment in a halfway house is not Covered.
- Codependency treatment is not Covered.
- Bereavement, pastoral/spiritual and sexual counseling are not Covered.
- Court-ordered treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Use Disorder programs, is not Covered.

Nutritional Support and Supplements

Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system for oral or tube feedings is not Covered.

Out-of-State Surcharges

Out-of-state surcharges are not Covered.

Palliative Care

Palliative care may be appropriate at any age and at any stage in a serious illness, and it can be provided together with curative treatments. Palliative care is not Covered under this plan.

Practitioner/Provider Services

Services provided by an Excluded Provider are not Covered. Any benefit or service, including pharmaceuticals, provided by an Excluded Provider as defined and maintained by the following regulatory agencies: Department of Health and Human Services; Office of the Inspector General (OIG); U.S. Department of Health; the General Services Administration; and the Office of Personnel Management, Office of Inspector General, which includes, but is not limited to, the:

- Excluded Parties Lists System (EPLS),
- List of Excluded Individuals/Entities (LEIE),
- Office of Personnel Management (OPM).

Office Visits, listed below, are not Covered.

- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided are not Covered.

Infertility services, listed below, are not Covered.

- Prescription Drugs and Injections
- Reversal of voluntary sterilization is not Covered.
- Donor sperm is not Covered.
- In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization are not Covered.
- Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue is not Covered.

Prescription Drugs/Medications

- Prescription Drugs/Medications that require a **Prior Authorization** when **Prior Authorization** was not obtained may not be Covered.

- New Prescription Drugs/Medications for which the determination of criteria for Coverage has not yet been established by our Pharmacy and Therapeutics Committee are not Covered.
- Prescription Drugs/Medications purchased outside the United States are not Covered.
- Prescription Drugs/Medications, medicines, treatments, procedures, or devices that we determine are Experimental or Investigational are not Covered.
- Prescription Drugs/Medications that have not been approved by the FDA are not Covered.
- Prescription Drugs/Medications prescribed for off-label or unproven indications when Medical Necessity has not been established are not Covered.
- Prescription Drugs/Medications that are identified by Drug Efficacy Study Implementation (DESI) as Less than Effective (LTE) DESI drugs are not Covered.
- Replacement Prescription Drugs/Medications resulting from loss, theft, or destruction are not Covered.
- Disposable medical supplies, except when provided in a Hospital or a Practitioner's/Provider's office or by a home health professional, are not Covered.
- Prescription Drugs/Medications used in conjunction with In-vitro fertilization and artificial insemination are not Covered.
- Oral or injectable medications used to promote pregnancy are not Covered.
- Over-the-counter (OTC) medications and drugs are not Covered. Refer to our *Formulary* for a list of Covered Over-the-counter (OTC) medications as determined by our Pharmacy and Therapeutics Committee.
- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are not Covered.
- Prescription Drugs/Medications for the purpose of weight reduction or control, except for Medically Necessary treatment for morbid obesity, are not Covered.
- Prescription Drugs/Medications used for cosmetic purposes are not Covered.
- Nutritional supplements as prescribed by the attending Practitioner/Provider or as sole source of nutrition are not Covered.
 - Infant formula is not Covered under any circumstance.
 - This does not apply to the nutritional supplements required under Home Health Services.
- Compounded Prescription Drugs/Medications are not Covered.
 - Bulk powders are not Covered.
 - Compounding kits are not Covered.
- Brand name drugs dispensed when a generic equivalent is available will not count towards Deductible or Out of Pocket Maximums, unless Medical Necessity has been met.
- Herbal or alternative medicine and holistic supplements are not Covered.
- Vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, or functional capacity examinations related to employment are not Covered.
- Immunizations for the purpose of foreign travel, flight and or passports are not Covered.

- Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy including “all-natural” pills, creams, lotions and gels, and non-FDA approved hormone pellets are Not Covered.
- Local Delivery of Antimicrobial Agents (LDAA) used for Periodontal Procedures are Not Covered.

Radiation

Any claim directly or indirectly caused by or contributed to or arising from ionizing radiation, pollution or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel, the radioactive toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof is not Covered.

Reconstructive Surgery for Cosmetic Purposes

Reconstructive Surgery for Cosmetic purposes is not Covered unless reconstruction is performed after a mastectomy.

Cosmetic Surgery is not Covered. Examples of Cosmetic Surgery include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, micro phlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.

Reconstructive Surgery regarding the breast and chest region related to Gender Confirmatory Therapy and Gender Affirming Care is a Covered benefit. The **Prior Authorization** criteria of this Plan is applicable.

Rehabilitation and Therapy

Rehabilitation and Therapy, as listed below, is not Covered.

Short or Long-term Rehabilitation services listed are not Covered:

- Athletic trainers or treatments delivered by Athletic trainers are not Covered.
- Vocational Rehabilitation Services are not Covered.
- Long-term Therapy or Rehabilitation Services are not Covered. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered Long-term Rehabilitation when:
 - You have reached maximum rehabilitation potential.
 - You have reached a point where Significant Improvement is unlikely to occur.
 - You have had therapy for four consecutive months.
 - Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, Cerebral Palsy, and Developmental Delays not associated with a defined event of illness or injury.

- Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, and Cerebral Palsy.

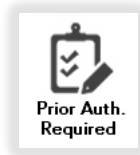
Speech Therapy services listed below are not Covered:

- Therapy for stuttering is not Covered.
- Voice Training is not Covered.
 - Gender Confirmatory Therapy and Gender Affirming Care is a Covered benefit and may be subject to Prior Authorization.
- Additional benefits beyond those listed in the **Speech Therapy Benefit Section** are not Covered.

Services for Which You or Your Dependent are Eligible under Any Governmental Program

Services for which you or your Dependent are eligible under any governmental program (except Medicaid), to the extent determined by law, are not Covered. Services for which, in the absence of any health service plan or insurance plan, no charge would be made to you or your Dependent, are not Covered.

Services Requiring Prior Authorization When Out-of-Network



If you fail to obtain **Prior Authorization** for services received Out-of-network that require **Prior Authorization**, those services are not Covered. However, Members are not liable when an In-network Practitioner/Provider does not obtain **Prior Authorization**. Refer to **Prior Authorization Section** for specific information. Prior Authorization is not required for Emergent or Urgent Care Services In- or Out-side of New Mexico.

Sexual Dysfunction Treatment

Treatment for sexual dysfunction, including medication, counseling, and clinics, are not Covered, except for penile prosthesis as listed in the **Benefits Section**.

Skilled Nursing Facility Care

Custodial or Domiciliary care is not Covered.

Smoking Cessation Services

Smoking Cessation services listed below are not Covered:

- Hypnotherapy for Smoking Cessation Counseling is not Covered,
- Over-the-counter (OTC) drugs are not Covered, unless listed as a Covered Over-the-counter (OTC) medication on our *Formulary*.
- Acupuncture for Smoking Cessation Counseling is not Covered.

Thermography

Thermography Services are not Covered.

Transplant Services

Transplant Services listed below are not Covered:

- Non-human Organ transplants, except for porcine (pig) heart valve, are not Covered.
- Transportation costs for deceased Members are not Covered.
- The medical and Hospital services of an Organ transplant donor (i.e., living donor) when the recipient of an Organ transplant is not a Member or when the transplant procedure is not a Covered Benefit are not Covered.
- Travel and lodging expenses are not Covered except as provided in the **Benefits Section**.

Treatment While Incarcerated

Services or supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison are not Covered.

War

Any claim directly or indirectly occasioned by, happening through, or in consequence of war, acts of foreign enemies, hostilities (whether war be declared), acts of terrorism, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition or destruction of or damage to property by or under the order of government or public or local authority is not Covered.

Women's Healthcare

Elective abortions after the 24th week of pregnancy are not Covered.

Maternity and newborn care, as follows, are not Covered:

- Use of an emergency facility for non-emergent services is not Covered.
- Elective Home Birth and any prenatal or postpartum services connected with an Elective Home Birth are not Covered. Allowable sites for a delivery of a child are Hospitals and licensed birthing centers. Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

Work-related Illnesses or Injuries

Work-related illnesses or injuries are not Covered, even if:

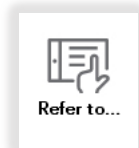
- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation Insurance.
- You fail to comply with any other provisions of the law.

If your employer fails to provide the required Worker's Compensation Insurance, proof of denial of Worker's Compensation is required for Presbyterian to cover the services under the medical benefit plan.

Claims

Your healthcare benefits are considered and paid according to the conditions outlined in this Section. If you paid a Provider for services, this Section outlines the process to follow for reimbursement.

When services are obtained from an In-network Practitioner/Provider, the Practitioner/Provider will submit the claim to Presbyterian for you. It is important that you provide your current

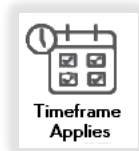


Presbyterian identification card to the Practitioner/Provider so they may obtain the mailing address listed on the back of the card. Services obtained from In-network Practitioners/Providers may require Cost Sharing amounts (Copayments, Deductible and/or Coinsurance) that you pay at the time of service. The amount of your Cost Sharing responsibility for each service can be found in your *Summary of Benefits and Coverage*.

Out-of-network Practitioners/Providers may require payment in full at the time of service and may refuse to file a claim. When this happens, you must pay the Out-of-network Practitioner/Provider and then file a claim for reimbursement with us.

Notice of Claim

The timely filing limit for an In-network Practitioner/Provider is **90 days** from the date of service, whereas the timely filing limit for an Out-of-network Practitioner/Provider is **one year** from the date of service.



Written notice of claim must be given to us within **20 days** after the date of loss or as soon as reasonably possible. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

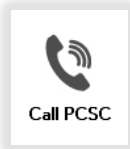
You may call or write to us to notify us of a claim. Presbyterian Insurance Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within **15 days** after the giving of such notice the Member shall be deemed to have complied with the requirements of this policy as to the proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. You may access our website at <https://www.phs.org/health-plans> and select **Find a Form or Document** to obtain a claim form.

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof

within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

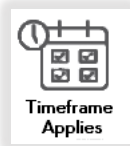
In-network Practitioners/Providers

We reimburse In-network Practitioners/Providers for Covered services provided to you. You should not be required to pay sums to any In-network Practitioner/Provider, except for the required Cost Sharing amount. You will be responsible for the payment of fees charged for missed appointments or appointments canceled without adequate notice, if any.

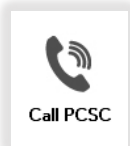


If you are asked by an In-network Practitioner/Provider to make any payments in addition to the Cost Sharing amount specified in this Plan, you should consult our Presbyterian Customer Service Center at **(505) 923-6980** or **1-800-923-6980**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711** before making any such additional payments. You will not be liable to an In-network Practitioner/Provider for any sums that we owe the Practitioner/Provider. Presbyterian does not discriminate against any health care provider who is acting within the scope of their license or certification under applicable State law.

Procedure for Reimbursement



When you receive Covered Services from a Practitioner/Provider and the Practitioner/Provider charged for that service, written proof (claim) of such charge must be furnished to us within **90 days** from the date of service for In-network Practitioners/Providers and within **one year** from the date of service for Out-of-network Practitioners/Providers in order for you to receive reimbursement. If you are relying on an Out-of-network Practitioner/Provider to furnish a claim on your behalf, you are responsible for ensuring claims have been submitted within **one year** from the date of service. Any such charge shall be paid upon our receipt of a Practitioner/Provider billing or completed valid claim for the Healthcare Services for which claim is made.



If you need a claim form or have questions regarding a charge made by your Practitioner/Provider, please contact our Presbyterian Customer Service Center at **(505) 923-6980** or **1-800-923-6980**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Claim forms are also available on our website at www.phs.org.

Please submit your completed claim form to:

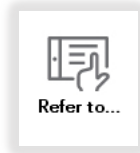
Presbyterian Insurance Company, Inc.
Attn: Claims
P.O. Box 26267
Albuquerque, NM 87125-6267

Services Received Outside the United States

Benefits are available for Emergency Healthcare Services and Urgent Care services received outside the United States. These services are Covered as explained in the **Benefits Section**. You are responsible for ensuring that claims sent to us, at the address cited above, are appropriately translated and that the monetary exchange rate effective on the date(s) you received medical care is clearly identified when submitting claims for services received outside the United States.

Presbyterian cannot reimburse foreign Practitioners/Providers. You should then submit the claim, or a summary of the medical services rendered, in addition to Proof of Payment. Proof of payment includes a copy of endorsed check, credit card statement or receipt showing that the services were paid in full.

Claim Fraud



Anyone who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate your Coverage for any type of fraudulent activity. For further information regarding Fraud, refer to the **General Provisions Section**.

Indemnity

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Claims are Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this Plan on account of hospital, nursing, medical or surgical services may, at the insurance company's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

Effects of Other Coverage

This Section explains how we will coordinate benefits should you have medical coverage through another Health Benefits Plan.

Coordination of Benefits

If you have medical coverage under any other Health Benefits Plan, other public or private group programs, or any other health insurance policy, the benefits provided or payable hereunder shall be reduced to the extent that benefits are available to you under such other plan, policy or program.

Coordination of Benefits (COB) applies to this Plan when a Member has medical benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual medical bills. PIC coordinates benefits according to the “Standard Other Insurance Rule”. Please contact the Presbyterian Customer Service Center for additional information on this rule. Also, each plan determines the maximum allowable payment for a given service and this maximum allowable may vary by plan. For this reason, there is no guarantee that 100 percent (**100%**) of the charges will be paid even when a Member has more than one medical plan.

The rules establishing the order of benefit determination between this Plan and any other plan covering a Member not on COBRA continuation on whose behalf a claim is made are as follows:

- Employee/Dependent Rule
 - The plan, which covers you as an employee, pays first.
 - The plan, which covers you as a Dependent, pays second.
- Active/Inactive Employee
 - The plan, which covers you as an active employee (or Dependent of an active employee), pays first.
 - The plan, which covers you as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.
- Longer/Shorter Employment
 - In the case where you are the Subscriber under more than one group health insurance policy, then the plan that has Covered you for a longer period of time will pay first. A change of insurance carrier by the group employer does not constitute the start of a new plan.
- If you are covered under a motor vehicle or homeowner’s insurance policy which provides benefits for medical expenses resulting from a motor vehicle accident or accident in your own home, you shall not be entitled to benefits under this Plan for injuries arising out of such accident to the extent they are covered by the motor vehicle or homeowner’s insurance policy. If we have provided such benefits, we shall have the right to recover any benefits we have provided from you or from the motor vehicle or homeowner’s insurance to the extent they are available under the motor vehicle or homeowner’s insurance policy.

- If you or your Dependents are Covered by COBRA continuation and are also Covered by another group plan, you shall receive our Covered Benefits to the extent that we will be secondary payer of all eligible charges, subject to the terms, conditions, exclusions and limitations of this Plan.

In no event shall the Covered Benefits received under this Plan and all other plans combined exceed the total reasonable actual expenses for the services provided under this Plan.

For purposes of coordination of benefits,

- We may release, request, or obtain claim information from any individual or organization. In addition, any Member claiming benefits from us shall furnish us with any information which we may require.
- We have the right, if we make overpayments because of your failure to report other coverage or any other reason, to recover such excess payment from any individual to whom, or for whom, such payments were made.
- We will not be obligated to pay for non-Covered Services or Covered Benefits not obtained in compliance with our policies and procedures.

Medicare

If you are enrolled in Medicare, the Covered Benefits provided by this Plan are not designed to duplicate any benefit to which you are entitled under the Social Security Act. Covered Benefits will be coordinated in compliance with current applicable federal regulations.

Medicaid

The Covered Benefits payable by us under this Plan, on behalf of a Member who is qualified for Medicaid, will be paid to the state Human Services Department, or its designee, when:

- The Human Services Department has paid or is paying benefits on behalf of the Member under the state's Medicaid program pursuant to Title XIX and/or Title XXI of the Federal Social Security Act.
- The payment for the services in question has been made by the state Human Services Department to the Medicaid Practitioner/Provider.

Subrogation (Recovering Healthcare Expenses from Others)

The Covered Benefits under this Plan will be available to you if you are injured by the act or omission of another person, firm, operation or entity. If you receive Covered Benefits under this Plan for treatment of such injuries, we will be subrogated to your rights or the Personal Representative of a deceased Member, or Dependent Member, to the extent of all such payments made by us for such benefits. This means that if we provide or pay Covered Benefits, you must repay us the amounts recovered for all such payments made by us in any lawsuit, settlement, or by any other means. This rule applies to any and all monies you may receive from any third party

or insurer, or from any uninsured or underinsured motorist insurance benefits, as well as from any other person, organization or entity.

By way of illustration only, our right of subrogation includes, but is not limited to, the right to be repaid when you recover money for personal injury sustained in a car accident. The subrogation right applies whether you recover directly from the wrongdoer or from the wrongdoer's insurer, or from your uninsured motorist insurance coverage. You agree to sign and deliver to us such documents and papers as may be necessary to protect our subrogation right. You also agree to keep us advised of:

- Any claims or lawsuits made against any person, firm or entity responsible for any injuries for which we have paid Covered Benefits.
- Any claim or lawsuit against any insurance company, or uninsured or underinsured motorist insurance carrier.

Settlement of a legal claim or controversy without prior notice to us is a violation of this Plan. In the event you fail to cooperate with us or take any other action, through agents or otherwise, which interferes with the exercise of our subrogation right, we may have, and hereby expressly reserve, all legal remedies available to us.

When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both you and us, we will, upon request by you or your attorney, share such collection costs and legal expenses, in a manner that is fair and equitable, but only if we receive appropriate documentation of such collection costs and legal expenses.

Appeals and Grievance Process Summary

Many grievances or problems can be handled informally by calling the Presbyterian Customer Service Center (PCSC) at **(505) 923-5678** or **1-800-356-2219 (TTY 711)**. You can also visit our website at www.phs.org.

Any grievance may be submitted orally or in writing. If you make an oral grievance, the PCSC will assist you to complete the required forms. Please be advised that Presbyterian Insurance Company, Inc. (PIC) shall not take any retaliatory action against you for filing a complaint.

Appeals

PIC will administer Level I and Level II appeals on behalf of this group according to the procedures set forth below. These procedures apply to appeals of adverse benefit determinations based on medical necessity, appropriateness, healthcare setting level of care, effectiveness of a covered benefit and/or rescission of coverage in the event of fraud or intentional misrepresentation of material fact. (Note: PIC responds to all urgent or expedited requests within 24 hours of receiving the request.)

Level I Appeals

To initiate a Level I appeal, a plan participant (all references to participant in the complaints, grievance and appeals section of the Summary Plan Description (SPD) include the subscriber and/or covered dependent(s) must submit a request for an appeal to PIC within **180 days** of receipt of a notice of denial of items or services under the plan. The participant must tell PIC the reason why the denial should be overturned and include any information supporting the appeal. PIC will acknowledge to the participant in writing within **three working days** that it has received a request for an appeal. The acknowledgement letter will contain the name, address, and direct phone number of an individual at PIC who may be contacted regarding the appeal.

Timeframes for Processing Appeals of Adverse Determinations

Level I appeals involving the review of a denial of coverage for services before they are received (pre- service) will be completed within **30 calendar days** of receipt of a standard appeal request. Appeals involving the review of a denial of coverage of services after they are received (post-service) will be completed within **60 calendar days**. Some appeals of pre-service denials relating to claims involving urgent care are processed on an expedited basis. Expedited decisions are made when a participant's life or health, or ability to regain maximum function, would be jeopardized by following the standard appeal process and time frames or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In cases that require an expedited decision of a pre- service request, based at the request of a participating provider or participant, a decision will be made within **72 hours** of the receipt of the request. PIC will not conduct expedited appeals for services already provided ("post service") to a participant. If a participant requests an expedited decision, a PIC medical

director will review the request. If the medical director determines that the request for an expedited appeal is medically necessary, a decision will be made within **72 hours** of the request. All required information will be transmitted between PIC, the applicable provider, and the participant by the quickest means possible. If the medical director determines that a request for an expedited appeal is not medically necessary, PIC will notify the applicable participant and then process the appeal within **30 calendar days**.

Internal Review of Appeal of Adverse Determination by Medical Director Level I

The appeal will be reviewed by a PIC medical director not involved in the initial determination, nor by a subordinate of the person resolving the claim initially. The medical director will re-review the request to make a determination regarding whether the requested healthcare services are medically necessary and covered under the plan. If medical judgment is involved, the PIC medical director will utilize input from a healthcare professional with training and experience in the relevant field.

Notice of Decision on Appeal of Adverse Determination by Medical Director

If the medical director decides to reverse an initial adverse determination, PIC will approve coverage of the services. The applicable participant and the applicable provider will be notified by mail or electronic means (fax, email, etc.) within **two working days** of such decision.

If the medical director decides to uphold an initial adverse determination, the applicable participant and the applicable provider will be notified by phone within **24 hours** that the adverse determination has been upheld and by written or electronic means within **one working day** of the phone notification.

Written notification must be provided in a language understood by the participant. The notice will provide the opportunity to request diagnosis and treatment codes and their meanings. The participant will be given the choice of whether or not to pursue a Level II appeal. If the participant does not wish to pursue the appeal, PIC will mail to the participant written notification of the decision and confirmation of the participant's decision not to pursue the appeal within **three working days** of the medical director's decision. If PIC is unable to contact the participant by phone within **72 hours** after making the decision to uphold the initial adverse determination, then PIC will notify the participant by mail of the decision. Included in the notification will be a self-addressed stamped response letter which asks whether the participant wants to pursue the Level II appeal by asking the participant to check "yes" or "no" on the letter. If the participant does not return the letter within **10 working days**, PIC will again try to contact the participant by phone. If the participant does not respond to PIC's phone calls and does not return the response letter within **20 working days** of the written notification to uphold the initial decision, PIC will close the file, documenting that the participant has not responded.

If the appeal was processed on an expedited basis, then a Level II appeal will automatically proceed. This review will be completed within **72 hours**. If an expedited review is conducted

during a participant's stay or course of treatment, coverage for healthcare services will be continued subject to applicable copayments and deductibles until PIC makes a decision and notifies the participant. If the participant does not make an immediate decision to pursue a Level II appeal, or if the participant requests additional time to supply supporting documents or information, the timeframes described above for completing an appeal will be extended to include the additional time the participant needs.

Internal Panel Review of Adverse Determination - Level II

If the participant requests a Level II appeal, then PIC will conduct the appeal on behalf of the employer according to the process set forth below.

Internal Panel Review Committee

An internal panel review committee will consider the appeal. The internal panel review committee will consist of PIC staff and one or more healthcare or other professionals. At least one of the healthcare professionals will have training and experience in the relevant field and practice in a specialty that would typically manage the case that is the subject under appeal or be mutually agreed upon by the participant and PIC. Panel members must be present physically or by video or phone conferencing to hear the appeal. A panel member who is not present to hear the appeal either physically or by video or phone conferencing will not participate in the decision.

Notice of Internal Panel Review Hearing

PIC will notify the participant in writing of the date, time, and place of the internal panel review hearing. The notice will also advise the participant of the participant's appeal rights. Such rights include:

- Attending and participating in the internal panel review
- Presenting a case to the internal panel review committee
- Submitting supporting material both before and at the internal panel review
- Asking questions of any representative of PIC
- Asking questions of the health care professionals on the internal panel review committee
- Being assisted or represented by a person of the participant's choice, including legal representation

A participant may hire a specialist to participate in the internal panel review at the participant's own expense. This specialist may not participate in making the decision.

If the participant chooses to have legal representation at the hearing, the participant must notify PIC prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed to complete the appeal. If PIC or employer has an attorney present to protect its interests, a notice will advise the participant of that and advising that the participant may wish

to obtain legal representation of his or her own. PIC will notify the participant of this at least **three working days** before the hearing.

PIC will accept a participant's reasonable request for postponement of a hearing. Timeframes previously described for completing an appeal will be extended during the period of any postponement.

Timeframes for Internal Panel Review Committee

No fewer than **three working days** prior to the internal panel review, PIC will provide the participant with:

- Pertinent records
- Treating provider's recommendation
- The PBB
- A copy of the notice of the adverse determination
- Uniform standards relevant to the participant's medical condition used by the internal panel in reviewing the adverse determinations
- Information provided to or received by any medical consultants retained by PIC
- All other evidence or documentation relevant to reviewing the adverse determination

The participant may review the claim file and present evidence and testimony as part of the appeals process, to the extent required by applicable law. Applicable law is defined as the regulations issued in the 29 CFR 2560.503-1 Federal Register and subsequent guidance, including any superseding regulations.

In addition to the claim file, the participant may review any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim.

The internal panel review committee will complete its review for expedited cases within **72 hours** of receipt of the request if the participant's life or health would be jeopardized or the participant's ability to retain maximum function would be jeopardized by a delay; or, in the opinion of physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The internal panel review committee will complete its review of a standard appeal within timeframes previously noted. PIC will notify the participant and the treating provider of the internal panel review committee's decision by phone within **24 hours** of making a decision, and in writing or by electronic means within **one working day** of the phone notice.

Individuals in urgent care situations and individuals receiving an ongoing course of treatment may proceed with an expedited external review by an independent review organization (IRO) at the same time as the internal review process occurs.

Notice of Decision of Internal Panel Review Committee

The written notice will contain the following:

- Names, titles, and qualifying credentials of the persons on the internal panel review committee
- A statement of the internal panel review committee's understanding of the nature of the appeal and all pertinent facts
- An explanation of the clinical or other rationale for the decision
- For coverage determinations, identification of the plan provision relied upon in reaching the decision
- The opportunity to request diagnosis and treatment codes and their meanings

The notice will also explain why each provision did or did not support the decision regarding coverage of the requested service. For medical necessity determinations, it will include the uniform standards relevant to the participant's medical condition, an explanation whether each supported or did not support the decision regarding the medical necessity of the coverage decision, and reference to evidence or documentation considered by the internal panel review committee in making the decision. The notice will also explain the participant's right to request an external review by an IRO. Review by an IRO is voluntary and explained in the next section. The participant must receive the written notice in a language understood by the participant.

Level III – External Review

If the participant is dissatisfied with the decision of the Internal Panel Review Committee, the participant may request an external review by an IRO as defined by applicable law. An IRO is an independent review organization, external to the employer and PIC that utilizes independent physicians with appropriate expertise to perform external reviews of appeals. This includes determining if surprise billing protections are applicable. The IRO will, with respect to claims involving investigational or experimental treatments, ensure adequate clinical and scientific experience and protocols are taken into account as part of the external review process. In rendering a decision, the IRO will consider any appropriate additional information submitted by the participant and will follow the plan documents governing the participant's benefits.

For claims involving urgent care, a participant may request an expedited external review if the adverse benefit determination involves a medical condition of the participant for which the regular time frame would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function, and the participant filed a request for an expedited internal appeal; or, if the final internal adverse benefit determination involved a situation where the participant had a medical condition where that time frame would pose such jeopardy, and if the final internal adverse benefit determination concerned an admission, availability of care, continued stay, or healthcare service for which the participant received emergency services and was not discharged from a facility.

Individuals in urgent care situations and individuals receiving an ongoing course of treatment may proceed with an expedited external review by an IRO at the same time as the internal review process occurs.

There are no fees or costs imposed on a participant for the external review of an appeal. The participant's decision as to whether or not to submit a denial of an appeal for external review will have no effect on the participant's rights to any other benefits under the plan.

You do not have to complete the internal appeal process before requesting an external review if:

- We fail to comply with requirements under federal regulations regarding denials and appeals, unless the failure to comply was a minor error that is not likely to cause prejudice or harm to you and was for good cause or a situation beyond our control, or
- We agree to waive the requirements for the internal appeal(s), or
- You are eligible for an urgent internal appeal, and request both an urgent internal appeal and urgent external review at the same time.

When an appeal is denied by PIC, the participant will receive a letter that describes the process to follow if the participant wishes to pursue an external review of an appeal through an IRO. If a participant files a request for an external review of an appeal with an IRO:

1. The external review may only be requested after exhaustion of the required internal appeal procedures under the plan, unless an expedited external review of a claim involving urgent care or an ongoing course of treatment is requested. Accordingly, the participant must first submit an appeal with PIC and receive a denial of appeal before requesting an external review of an appeal with an IRO.
2. After a participant receives a denial of an appeal, the participant must submit the request for external review of appeal with PIC in writing within **four months** from the date of receipt of the adverse benefit determination, extended to the next working day if the date falls on a weekend or federal holiday.
3. PIC will forward a copy of the final appeal denial letter and all other pertinent information that was reviewed in the appeal to the IRO. The participant may also submit additional information to be considered. The participant will have at least **five business days** to submit additional information to the IRO.
4. Within **five days** after receipt of the request for external review, the plan will complete a preliminary review to determine if the participant was covered under the plan at the time the service was requested or provided, whether the adverse benefit determination relates to the participant's failure to meet the eligibility requirements of the plan, whether the participant has exhausted the plan's internal appeal process, and whether the participant has provided all of the information and forms required to process an external review. Within **one business day** after completion of this preliminary review, the plan will provide the participant written notification giving any reasons for the ineligibility of the request for external review and describing the information or materials required, and the plan will allow the participant to perfect a request for external review within the four month filing period or within the 48 hour period following receipt of the notification, whichever is later.

5. The participant will be notified of the decision of the IRO within **45 days** of the receipt of the request for the external review of an appeal. The IRO's decision will include:
 - a. A general description of the reason for the request for external review.
 - b. The dates the IRO received the assignment to conduct the external review and the date of their decision.
 - c. Reference to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching their decision, taking into account adequate clinical and scientific experience and protocols with respect to claims involving experimental or investigational treatments.
 - d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision.
 - e. A statement that judicial review may be available.
 - f. Current contact information, including the phone number for any ombudsman established under the PHS Act.
 - g. In the event of an expedited external appeal for claims involving urgent care, the IRO will make the decision as expeditiously as the participant medical condition or circumstances require, but in no event more than **72 hours** after the IRO receives the request for an expedited external review and, if the notice is not in writing within **48 hours** after the date of providing the verbal notice, the IRO will provide written confirmation of the decision to the participant and the plan. Written notice must be provided in a language understood by the participant. The notice will provide the opportunity to request diagnosis and treatment codes and their meanings.
 - h. The decision of the IRO will be binding on the participant as well as the plan, except to the extent there may be other remedies available under state law.
6. The statute of limitations or other defense based on timeliness is suspended during the time that an external review of your appeal is pending. If the participant does not submit a request for external review of an appeal the employer and PIC waives any right to assert that the participant failed to exhaust administrative remedies.

Submit your request for an external review to:

Address: Presbyterian Insurance Company, Inc.
Appeals and Grievance Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone: (505) 923-6980 or 1-800-923-6980

Fax: (505) 923-6111

Email: gappeals@phs.org

Grievances

Participants may file a grievance if they are dissatisfied with any aspect of the plan other than a request for healthcare services, including, but not limited to:

- Administrative practices that affect the availability, delivery or quality of healthcare services
- Claims payment
- Handling or reimbursement for healthcare services
- Terminations of coverage

If the participant is unable to resolve the grievance with a customer service representative, the participant may file a formal grievance by notifying a customer service representative.

Initial Internal Review - Level I

Once the request has been received, PIC will send the participant written acknowledgement of the grievance within **three working days** after receipt. The letter will contain the name, address, and direct phone number of a PIC representative who may be contacted regarding the administrative grievance. The review of the grievance will be conducted by a PIC representative authorized to take action related to the grievance, if applicable, and will allow the participant to provide to PIC any information relevant to the grievance.

PIC will mail a written response to the participant within **60 calendar days** of receipt of the grievance. PIC's response letter to the participant shall contain:

- The name, title, and qualifications of the person conducting the initial review.
- A statement of the reviewer's understanding of the nature of the grievance and pertinent facts.
- A clear and complete explanation of the reason for the response/decision.
- The Plan provisions relied on in reaching the response.
- A statement that the initial decision will be binding unless the participant submits a request for reconsideration within 20 working days of the receipt of the initial response.
- A description of the procedures and deadlines for requesting reconsideration, including any necessary forms.

Reconsideration of Internal Review – Level II

If the participant is not satisfied with the outcome of the initial review, PIC will appoint a reconsideration committee consisting of PIC representatives who have not participated in the initial internal review, to review the grievance. The participant must request this committee hearing within **20 days** after receiving the response letter, or the initial review decision will be final.

Reconsideration Committee

Upon receipt of a request for a reconsideration committee hearing, PIC will schedule and hold a hearing within **15 working days** but no greater than **60 calendar days** from receipt of the Level I request. The hearing will be held during regular business hours at a location reasonably accessible to the participant. The participant will have the opportunity to participate at the committee meeting in person, by conference call, video conferencing, or other technology, at PIC's expense. PIC will not unreasonably deny a request for postponement of the hearing.

Reconsideration Committee Hearing

PIC will notify the participant in writing of the hearing date, time, and place of the reconsideration committee hearing at least 10 working days in advance. The notice will advise the participant of their rights: to attend the hearing; to present a case to the committee; to submit supporting material both before and at the hearing; to ask questions of any representative of PIC; and be assisted or represented by a person of the participant's choice that may or may not be a legal representation. If PIC will have an attorney to represent its interests; the notice will advise the participant of this and that the participant may wish to obtain legal representation of their own. If the participant chooses to have legal representation at the hearing, the participant must notify the grievance department representative prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed for administrative grievances. No fewer than **three working days** prior to the hearing, PIC will provide the participant with all the documents and information that the reconsideration committee will rely on in reviewing the grievance.

Decision of Reconsideration Committee

PIC will mail a written decision to the participant within **seven working days** after the committee hearing. The written decision will include the following:

- The names, titles, and qualifications of the persons on the committee
- The committee's statement of the issues involved in the grievance
- A clear and complete explanation of the rationale for the decision
- The Plan provision(s) relied on in reaching the decision
- References to the evidence or documentation relied on in reaching the decision
- A statement that the initial decision will be binding unless the participant submits a request for external review by the employer

Retaliatory Action

In accordance with the Patient Protection Act and the New Mexico Administrative Code for Managed Health Care 13.10.17.9 NMAC-N, 7-1-00, PIC cannot take retaliatory action against you for filing a grievance under this health plan.

Records

Your medical records are important documents needed in order to administer your Health Benefits Plan. This Section explains how we ensure the confidentiality of these records and how these records are used to administer your plan.

Creation of Non-Medical Records

We shall keep your records related to personal identification information, which does not specifically relate to your medical diagnosis or treatment. You shall forward information periodically to us as we may require in connection with the administration of this Plan.

Accuracy of Information

We shall not be liable to fulfill any obligation which is dependent upon information submitted by the group or by you prior to its receipt in a satisfactory manner. We are entitled to rely on such information as submitted. We at our sole discretion may make any necessary corrections due to recognizable clerical error. We will date and initial the correction of the error.

Consent for Use and Disclosure of Medical Records

We are entitled to receive from any Practitioner/Provider of services Protected Health Information (PHI) about you to the extent permitted by applicable law, for any permitted purpose, including but not limited to, quality assurance, Utilization Review, processing of claims, financial audits or other purposes related to payment and certain of our healthcare operation activities. A determination of benefit Coverage may be suspended pending receipt of this information. By acceptance of Coverage under this Plan, you give consent to each Practitioner/Provider rendering services hereunder to disclose all information to us (to the extent permitted by applicable law) pertaining to you for any permitted purpose specified in the law. This consent shall not permit a use or disclosure of PHI when an authorization is required by law or when another condition must be met for such use or disclosure to be permitted under applicable law. We will comply with the Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.

Professional Review

We are permitted by law to use your records to conduct professional/regulatory review programs for Healthcare Services without your consent/authorization. Such review programs include, but are not limited to, the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and the Office of the Superintendent of Insurance (OSI).

Confidentiality of Protected Health Information/Medical Records

You will receive a Notice of Privacy Practices that we issue, which will contain a statement of your rights with respect to PHI and a brief description of how you may exercise your rights.

What is PHI?

Protected Health Information, or PHI, is any health information about you that clearly identifies you or that could reasonably be used to identify you and your health needs that we send, receive, or keep as part of our daily work to improve your health. This includes information sent, received, and kept by electronic, written and oral means. Medical records and claims are two examples of PHI.

We keep your PHI safe. Unless otherwise permitted or required by law, we will not disclose confidential information without your consent/authorization. Your privacy in all settings is important to us.

As a Member you (or your legal guardian/Personal Representative) have the right to:

- Request restrictions on certain uses and disclosures of PHI, although we are not required to agree to a requested restriction.
- Receive confidential communications of PHI from us.
- With certain exceptions, inspect and receive a copy of PHI.
- Request an amendment to PHI you believe to be incorrect or incomplete.
- Receive an accounting of certain disclosures of PHI.
- Obtain a paper copy of the Notice of Privacy Practices from us upon request (even if you previously agreed to receive the Notice(s) electronically).

Access to PHI

All confidential documents are kept in a physically secure location with access limited to authorized Plan personnel only. You (or your legal guardian/Personal Representative) have the right, with certain exceptions, to request access to inspect and obtain a copy of your PHI. We may charge a reasonable fee for providing a copy, summary or explanation of the information you request. If there is a fee, we will tell you how much it will cost before we provide the requested information. You may change your request to avoid or reduce the fee.

You do not have the right to inspect or obtain a copy of PHI that consists of:

- Psychotherapy notes.
- Information gathered in reasonable expectation of, or for use in, a civil, criminal, or Administrative action or proceeding.
- PHI maintained by us that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 U.S.C. 263a, to the extent the provision of access to you would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988 (CLIA), pursuant to 42 CFR 493.3(a)(2).

To request access to inspect or obtain a copy of your PHI, you must submit your request in writing to:

Presbyterian Insurance Company, Inc.
Attn: Director, Presbyterian Customer Service Center
P.O. Box 26267
Albuquerque, NM 87125-6267

We will act on your request for access to PHI no later than **30 days** after receipt of the request. If we are unable to take an action within the required timeframe, the Plan may take up to **30 additional days**, provided that, no later than **30 days** after receiving your request, the Plan provides you with a written statement of the reason for the delay and date by which we will complete its action on your request.

Routine Uses and Disclosures of PHI

We routinely use PHI for a number of important and appropriate purposes, including:

- Claims payment
- Fraud and abuse prevention
- Data collection
- Performance measurements
- Meeting state and federal requirements
- Utilization management
- Accreditation activities
- Preventive health services
- Early detection and disease management programs
- Coordination of care
- Quality assessment and measurement, including surveys, research of Complaints and Grievances, billing and other stated uses
- Responding to your requests for information, products or services

We do not disclose PHI to anyone other than as permitted by the plan documents or required by law. We use and disclose information we collect only as necessary to deliver healthcare products and services to you in accordance with our Contracts, or to comply with legal requirements.

Our employees refer to your Personal Health Information only when necessary to perform assigned duties for their job. Our employees handle your health records according to our stringent confidentiality policies.

Consents/Authorizations

Although consent from you (or your legal guardian/Personal Representative) is not required to use or disclose PHI for certain purposes specified in the law, a Practitioner/Provider shall request that you (or your legal guardian/Personal Representative) sign a consent form permitting

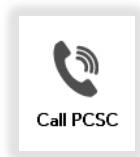
disclosure of medical records (to the extent permitted by law) to us at the time of your first visit to the Practitioner/Provider.

In the event that the Practitioner/Provider fails to obtain such consent for disclosure to us, or you refuse to sign such consent for disclosure to us, we shall use our best efforts to obtain such written consent from you (or your legal guardian/Personal Representative) prior to the Practitioner's/Provider's release of PHI (i.e., health records) to us for purposes permitted by law.

When you sign your enrollment form (Application), you are giving consent (to the extent permitted by applicable law) to the use or the release of your PHI by any person or entity including without limitation, Practitioners/Providers and insurance companies, to us or our designees (including its authorized agents, regulatory agencies and affiliates) for any permitted purpose, including but not limited to, quality assurance, Utilization Review, processing of claims, financial audits or other purposes related to the payment, or certain healthcare operations activities of our Plan. This consent does not permit a use or disclosure of PHI when an authorization is required by law.

We will not further release PHI about you without your permission/authorization unless permitted or required by law.

We require all In-network Practitioners/Providers and facilities to maintain confidential patient information in accordance with federal and state laws including, HIV/AIDS status, mental health, sexually transmitted infections (STIs) or Alcohol/Substance Use Disorder. State and federal law prohibits further disclosure of HIV/AIDS, other STIs, mental health and Alcohol Use Disorder and/or Substance Use Disorder information to any person or agency without obtaining specific valid written authorization for that purpose from the patient (or legal guardian/Personal Representative), or as otherwise permitted by state or federal law.



To request an Authorization Form, please contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711** or visit our website at www.phs.org. Authorization Forms will be kept in your medical record or enrollment file.

Members Who Are Unable to Give Consent/Authorization

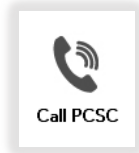
Sometimes courts or doctors decide that certain people are unable to understand enough to make decisions for themselves. Usually, a person with legal authority to make healthcare decisions for a child or other person (for example, a parent or legal guardian) can exercise the health information rights described herein for the child or other person, but not always. Unless otherwise required or permitted by law, when we need an Authorization Form signed for a person who can't make healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

Right to Request Amendments (Changes) to PHI

We recognize your right to request amendment of PHI or a record containing PHI for as long as the PHI is maintained in our records. Our Presbyterian Customer Service Center will accept written requests to amend PHI. We must approve or deny your request to amend the disputed PHI no later than **60 days** after receipt of the request. If we are unable to take an action within the required timeframe, we may take up to **30 additional days**, provided that, no later than **60 days** after receiving your request, we provide you with a written statement of the reason for the delay and date by which we will complete our action on your request and notify you in writing of the determination no later than **60 to 90 days** after receipt of such a request.

Process for Members to Request an Accounting of Disclosures of PHI

You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center by calling Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711** or visit our website at www.phs.org. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you to others without authorization from you.



Restriction of PHI Use or Disclosures

You (or your legal guardian/Personal Representative) have the right to request that use or disclosure of your PHI be restricted for the following purposes:

- Our treatment, payment and healthcare operations
- To persons involved in your care (i.e., family member, other relative, close personal friend, or any other person identified by you)
- For notification purposes of your location, general condition, or death
- To a public or private entity authorized by law or its charter to assist in disaster relief efforts

We are not required by law to agree to any requested restriction. If we agree to honor a requested restriction, we will not violate such restriction, except as permitted by law. We will accept your written request to restrict the use or disclosure of your PHI or will document your verbal request in our records.

Use of Measurement Data

It is important for us to know about your illnesses to help us improve the quality of care our healthcare Practitioners/Providers provide to you. We sometimes use medical data (laboratory results, diagnoses, etc.) which does not identify you for this purpose.

Internal Protection of Oral, Written and Electronic PHI Across PIC

To ensure internal protection of oral, written, and electronic PHI across our organization, the following rules are strictly adhered to:

- PHI is accessed by Plan personnel only if such information is necessary to the performance of job-related tasks.
- PHI is not discussed inside or outside our facility unless the data is necessary to the performance of job-related tasks.
- PHI reports and other written materials are reasonably safeguarded throughout the facility against unauthorized access by Plan personnel or public viewing.
- All employees, volunteers, and any external entity with a business relationship with us that involves health information will be held responsible for the proper handling of our data and business communications and are required to sign a confidentiality statement or business associate agreement, respectively.

Violation of the above rules by any member of our workforce is grounds for disciplinary action, up to and including immediate dismissal.

Website Internet Information

We enforce security measures to protect PHI that is maintained on the website, network, software, and applications. We collect two types of information from visitors to our website:

- Website traffic statistics, including:
 - Where visitor traffic comes from
 - How traffic flows within the website
 - Browser type

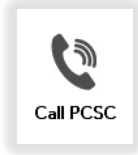
We monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful.

- Personal information that you provide to us (such as your name, address, billing information, Health Benefit Plan enrollment status, etc.) if you fill out a form on our website.
 - We use your personal information to reply to your concerns. We save this information as needed to keep responsible records and handle inquiries.
 - We do not sell, trade, or rent personal information provided by visitors to our website to other persons, companies or partners.

Protection of Information Disclosed to Plan Sponsors, Employers or Government Agencies

Our policies and procedures prohibit sharing your PHI with any fully insured employer Group's plan sponsor without your (or your legal guardian/Personal Representative's) authorization. We are careful not to release PHI to your employer as part of routine financial and operating reports. We may disclose summary health information that does not identify you to plan sponsors for allowable purposes. We may disclose information to government agencies or accrediting

organizations that monitor our compliance with applicable laws and standards as permitted by law.



If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980** or **1-800-923-6980**. Hearing impaired users may call **TTY 711** or visit our website at www.phs.org.

Eligibility, Enrollment, Effective Dates, Termination and Continuation

This Section explains eligibility requirements for Subscribers and/or their Dependents, important effective dates, conditions for Termination of Coverage and continuing Coverage for Members who become ineligible for this plan.

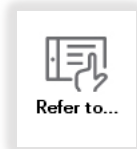
How You Can Enroll as a Member

To be eligible for Covered Benefits in accordance with the terms of this Plan, you must be enrolled as a Member. To be eligible to enroll as a Member, you must be a Subscriber or a Dependent of the Subscriber and meet the criteria listed below.

Eligible Subscribers

A Subscriber is the person whose employment with the Employer (Group), or other status is the basis for enrollment eligibility. To be eligible to enroll as a Subscriber, you must:

- Be an active permanent full-time employee of the Group who is currently working the minimum number of hours specified in the Administrative Services Agreement (ASA) and has completed the required probationary period and the required waiting period.
 - Waiting periods are established by the Employer upon application for the group and are determined at the sole discretion of the Employer, not to exceed 90 days from date of hire.
- Physically live or work in the State of New Mexico, our Service Area.
- Continue to meet your Group specific enrollment and eligibility requirements as outlined in the ASA.



A Subscriber who has had a prior Contract or Plan with us terminated for Good Cause, as described in the **Glossary of Terms Section** or under any similar Sections of our other Plans, is not eligible to enroll.



To learn about eligibility criteria required by your Group, you may contact your Group's benefits administrator.

You must provide proof that you meet the **eligibility requirements** required by your Group and as stated in your Application.

Eligible Dependents

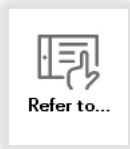
A Dependent is a family member of a Subscriber as described in this Section. To be eligible to enroll as a Dependent for Coverage and become a Member, your Dependent must be:

- Your legally married Spouse (of the Subscriber), as defined by state law:
 - Physically live or work in the State of New Mexico, our Service Area.

- Your Domestic Partner as defined by and if specified as eligible by your Employer Group.
- Your Dependent child who is:
 - Under **26 years** of age; your natural child, a legally adopted child, or a child for whom you are legal guardian or have legal custody as defined by state law.
 - Your stepchild (foster children are not eligible).
 - A child of non-custodial parent(s).
 - In your custodial care as appointed by court order.
 - A child for which a court or qualified administrative order is imposed.
 - You or your Spouse's Dependent child for whom you are required by court order to provide healthcare Coverage.

We will require proof, such as legal adoption or guardianship papers, income tax forms, court orders or administrative orders that a child qualifies as a Dependent for Coverage under this Plan.

The enrollment of a Dependent child for Covered Benefits under this Contract shall terminate at the end of the month of the child's 26th birthday unless the Dependent child is totally and permanently disabled. For the process for Continuation of Coverage see page 118.



A Dependent who has had a prior Contract or Plan with us terminated for Good Cause, as described in the **Glossary of Terms Section** or under any similar Sections of our other Plans, is not eligible to enroll.

Court Ordered Coverage for Dependent Children in the Service Area

The Dependent who is eligible due to a court order will be allowed to apply. Other siblings of the court-ordered Dependent, who do not meet the eligibility requirements as explained above, will not be eligible for Coverage.

Dependents of Non-Custodial Parents

When a Dependent child has Coverage through a non-custodial parent, we shall:

- Provide such information to the custodial parent as may be necessary for the child to obtain Covered Benefits.
- Permit the custodial parent or the Practitioner/Provider, with the custodial parent's approval, to submit claims for Covered Benefits without the approval of the non-custodial parent.
- Make payment on claims for Covered Benefits submitted by the custodial parent (as explained above) directly to the custodial parent, the Practitioner/Provider or the state Medicaid agency.

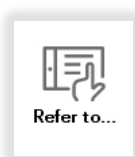
Residence of a Dependent Child

Dependent Student



Dependent Students attending school within New Mexico may either receive care through their PCP or at the Student Health Center. A **Prior Authorization** form is not needed prior to receiving care from the Student Health Center.

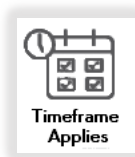
Dependent Students attending school outside of New Mexico may also receive care at the Student Health Center without **Prior Authorization** from us. Services provided outside of the Student Health Center are limited to Medically Necessary services for the initial care or treatment of Emergency Healthcare Services or an Urgent Care situation.



For emergencies outside of New Mexico, you may seek Emergency Healthcare Services from the nearest appropriate facility where emergency medical treatment can be provided. Refer to the **Benefits Section; Accidental Injury (Trauma)/ Urgent Care / Emergency Healthcare Services / Observation** for further information on Emergency Healthcare Services and follow-up care.

Total and Permanent Disability of an Enrolled Dependent Child

When an enrolled Dependent child reaches his or her **26th birthday** and is totally and permanently disabled, the Coverage of the Dependent under this Plan will not terminate. The enrolled Dependent must be incapable of self-sustaining employment by reason of mental or



physical disability and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish us with proof of such disability, incapacity and dependence within **31 days** of the Dependent child's attainment of age 26. If we approve continued Coverage, we may request proof of the disability on each birthday after the two-year period following the attainment of age 26.

Medicare-Eligible Members (TEFRA)

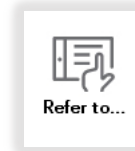
Shortly before you turn age 65 or qualify for Medicare Benefits, you are responsible for contacting the local Social Security office to establish your Medicare eligibility. You should then contact your Group's benefits administrator to discuss your Coverage choices.

- If Medicare is Secondary (TEFRA)
 - If your Group is subject to the Tax Equity & Fiscal Responsibility Act (TEFRA) and if you are actively at work at age 65 and older, you may continue the Coverage provided under this Plan until you retire. In that case, this Coverage will be primary over Medicare benefits. There may be other circumstances that allow you to retain this Coverage when you are eligible for Medicare. You should contact the Social Security Administration for more information.
- If Medicare is Primary

- If you are eligible for Medicare and you select Medicare as your primary health plan, the Coverage under this Plan is not available to you.
- If your Group is not subject to the federal law (TEFRA) and is not required to offer Group Coverage that you may select to be primary over Medicare when you are actively working at age 65 and beyond the following may apply:
 - Active employees and their dependents who are enrolled in conventional coverage may also enroll in our Group healthcare Plans.
 - For Groups with 2-19 total employees, Medicare Parts A&B are considered the Primary insurance carrier and we would be the secondary carrier.
- If your Group does not offer Coverage secondary to Medicare, please refer to “Continuation of Coverage” later in this Section for more Coverage options.

Subscribers and Dependents Who May NOT Enroll

- A Subscriber’s grandchild is not eligible for Coverage unless the grandchild meets the eligibility criteria for a Dependent.
- A child born of a Member, when the Member is acting as a surrogate parent, is not eligible for Coverage.
- A Subscriber and/or Dependent is not eligible to enroll for Coverage if either Subscriber or Dependent has had a prior Contract or Plan with us terminated for Good Cause as described in the **Glossary of Terms Section** or under any similar Sections of our other Plans, unless we review and approve the new enrollment, in writing.



Enrollment and Effective Dates

If you meet the Subscriber or Dependent eligibility criteria, you may enroll in our Coverage by submitting a completed Application, together with any required Prepayment, at the appropriate times as discussed below.

When Your Employer signs our Administrative Services Agreement (ASA)- The Initial Group Enrollment Period

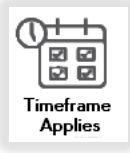
A Subscriber and the eligible Dependents may enroll during the Initial Group Enrollment Period, after the Employer and our Company execute the Administrative Services Agreement (ASA). If you, as the Subscriber, were hired as a full-time employee and your employer is not waiving the initial waiting period, you must meet the Employer’s waiting period requirements.



You (as the Subscriber) and your eligible Dependents must complete and sign an Application and submit it with any required Prepayment to the Group. We must receive the signed and completed Application, along with any required Prepayment, within **31 days** of the initial effective date of the Plan.

The Annual Group Enrollment Period

Each year there will be an Annual Group Enrollment Period. During the Annual Group Enrollment Period, Subscribers and their eligible Dependents who were previously eligible but have not previously enrolled in our Coverage may enroll. The effective date of Coverage for new Members who enroll during the Annual Group Enrollment Period shall be 12:01 a.m. on the date of the Contract Year for which they enroll. We must receive the signed and completed Application and any required Prepayment within **31 days** of the initial effective date of the Plan.



Newly Hired Employees During the Year

If you are hired by the Group after an Annual Group Enrollment Period, you must enroll, along with eligible Dependents, within **31 days** after becoming eligible. The effective time and date of Coverage will be 12:01 a.m. on the first of the month following completion of the Group's eligibility requirements and submission of the completed and signed Application. If you do not enroll within the **31-day period**, the earliest time you and your eligible Dependents may enroll is the next occurring Annual Group Enrollment Period except as specifically described in the **Special Enrollment Section**.



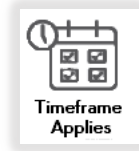
Family Status or Employment Status Changes During the Year

During the Contract Year when you are currently enrolled as a Subscriber, you may make certain changes to your benefit election due to a change in family or employment status. We will require evidence of a change in family or employment status in order to change your benefit election. You must complete and sign an Application and submit it with any additional Prepayment amount, within **31 days** of the date of the change in family or employment status. Terminating Coverage for a Dependent from your benefit plan Coverage is not an event that allows you to change your benefit Plan.

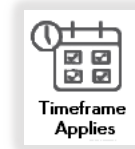


We recognize the following family status changes as a reason for adding or removing Dependents:

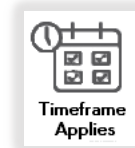
- Marriage:
 - Your newly acquired Spouse (and any children of the Spouse eligible for Coverage under this Section) is eligible to be enrolled as a Dependent. You must complete and sign an Application and submit it, along with any required Prepayment, to your Employer Group within **31 days** from the date of marriage. Coverage will become effective on the first day of the month following the date of marriage.
- Divorce or legal separation:
 - You must notify us within **31 days** of the date of divorce or legal separation of the change in Dependent Coverage and submit any Prepayment amount. Coverage will be effective as of the first day of the month following the date we receive the notification.



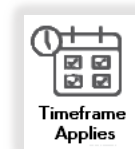
- Birth of a child:
 - Your newborn or the newborn of your Spouse will be Covered from the moment of birth when enrolled as follows:
 - We must receive the signed and completed Application that was submitted to the Employer Group within **31 days** from the date of birth.
 - If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed Application within the first **31 days** following the date of birth.
 - If the above two conditions are not met, we will not enroll the newborn for Coverage until the next following Annual Group Enrollment Period. Please refer to the **Benefits Section, Prior Authorization Section, Limitations Section and Exclusions Section** to fully understand the benefits and requirements for Maternity and newborn Coverage.



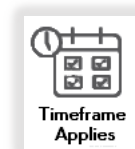
- Adoption of a child:
 - A child under age 18 who is placed in your home for the purposes of adoption and for whom you have commenced adoption proceedings is eligible to be enrolled as a Dependent.
 - The child will be Covered from the date of placement for the purpose of adoption when we receive the signed and completed Application that was submitted to the Group and any applicable Prepayment made within **31 days** the date of placement.
 - The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child.
 - Such child shall continue to be eligible for Coverage unless placement is disrupted prior to legal adoption. The legal obligation terminates when placement terminates or is disrupted.



- Legal Guardianship:
 - If you or your Spouse becomes the legal guardian for any child pursuant to court order, the child is eligible to be enrolled as a Dependent. You must submit a completed, signed Application and any applicable Prepayment within **31 days** of the court and/or qualified administrative order granting guardianship.
 - The Dependent child will become a Member on the first day of the month following the date the order is filed with the clerk of the court. The Dependent child will continue to be eligible until such time as you or your Spouse are no longer the legal guardian for such child.

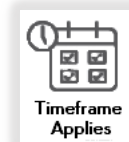


- Court ordered or qualified administrative ordered eligible Dependent Coverage:
 - If you are required by a court or administrative order to provide Coverage for an eligible Dependent child, the Dependent child may be enrolled. You must submit a completed and signed Application and any applicable Prepayment within **31 days** of the court order.

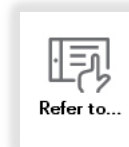


The Coverage for the eligible Dependent child will become effective on the date in accordance with the court or administrative order. If the court order does not stipulate an effective date, the Dependent child will become Covered effective the first day of the month following the date the order was filed as public record with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent child will be the first day of the month following the Employer's receipt of the request.

- When a Subscriber, who is not enrolled in our Coverage, has been ordered by a court of law or by a qualified administrative order to provide healthcare Coverage for a Dependent child, the child is eligible to be enrolled as a Dependent provided the Subscriber has met the Group's waiting period requirements and the signed Application together with any required Prepayment is submitted within **31 days** from the date on which the Group receives the court and/or qualified administrative order. The Dependent child will become a Member on the day stipulated by the court order.
- If the Subscriber, who is not enrolled in our Coverage, has not met the waiting period and other eligibility requirements, the Subscriber may not enroll and may not enroll the Dependent child until the date that eligibility requirements have been met. The Subscriber must submit the Application and any Prepayment within **31 days** from the eligibility date. The Dependent will become a Member on the date of the Application.
- Note: Only the eligible court-ordered Dependent(s) will be allowed to enroll as a result of the court and/or qualified administrative order. Other Dependents who are not enrolled may not enroll at this time.



- The last day of the month in which your Dependent child turns age 26 (when Dependent Coverage will terminate unless the Dependent child is as described in the **Totally and Permanently Disabled Dependent Child in this Section**)
- The death of your Spouse or Dependent child
- Disqualification or requalification of your Dependent



We recognize the following changes in Employment Status as a reason for making a change in your benefit election:

- A change in your (Subscriber) Spouse's employment such as loss of job or a new job that provides Dependent care assistance or other healthcare Coverage. Annual Group Enrollment for a Spouse's plan is not an employment status change.
- Unpaid leave of absence for the Subscriber or Dependent Spouse
- Significant change in the cost of a Spouse's current plan (50 percent (50%) or greater)
- Employment transfer that results in a change of residence

Any change in your Covered Benefit election that you apply for because of a family status or employment status change will become effective on the first day of the month following the date of the status change if you have met the waiting period and other employer Group eligibility requirements. The only exceptions would be the birth and adoption of a child, or court-ordered

Coverage, where the change in Coverage would be effective as of the date of birth or placement for adoption and a court-ordered change if the court specifies an effective date.

Special Enrollment for Active Employees and Their Dependents

If you, as a Subscriber, failed to enroll in our Coverage during a previous Annual Group Enrollment Period or within **31 days** after meeting your Employer's waiting period and you became originally eligible, you may enroll during the year due to a Special Enrollment qualifying event.

There are three Special Enrollment qualifying events that will allow you to enroll other than at the Annual Enrollment Period. They are as follows:

- Change in family status by acquiring a new Dependent(s)
- Loss of other prior Coverage
- Loss of Medicaid/CHIP eligibility



You must apply within **31 days** from the date of a Special Enrollment qualifying event, or within **60 days** from the loss of Medicaid/CHIP eligibility. If you do not request Special Enrollment within the required period specified, you will not be eligible to enroll until the next Annual Enrollment Period.

Special Enrollment - Change in Family Status

If you (Subscriber) are eligible and not enrolled and if you acquire a new Dependent due to marriage, the birth of your natural child or adoption of a child, you and your eligible Dependents



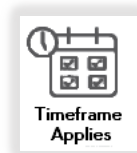
may apply for Coverage under the Special Enrollment qualifying event. You must complete, sign and submit an Application, along with required Prepayment, within **31 days** of the marriage, birth or placement for adoption. If you fail to submit an Application within **31 days** of the change in family status, special enrollment is not available.

In the case of marriage, you and your Spouse and any Dependent children acquired because of the marriage may enroll.

In the case of a newborn or adopted child, you, your Spouse, and the newborn or adopted child who triggered the event may enroll. The other siblings who are not enrolled may not enroll until the next Annual Group Enrollment Period.

Effective date of the Family Special Enrollment:

- In the case of marriage, the first day of the first calendar month following the date of the marriage, provided that we receive the completed Application and any required Prepayment within **31 days** of the date of marriage.

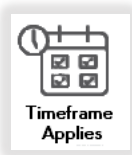


- In the case of a Dependent’s birth, the date of such birth provided that we receive the completed Application and any required Prepayment within **31 days** of the date of birth.
- In the case of adoption or placement for adoption, the date of such adoption or placement for adoption provided that we receive the completed Application and any required Prepayment within **31 days** of the date of adoption.

Special Enrollment - Loss of Coverage

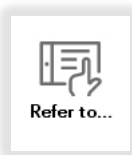
If you (an eligible Subscriber) and/or your eligible Dependent initially declined to enroll in our Coverage because you or your Dependent had other medical coverage and later involuntarily lost the other coverage, the eligible person may enroll as a Subscriber or as a Dependent after the initial eligibility period if the person loses coverage under all of the following circumstances:

- The person was covered under a Group Health Benefits Plan or had individual health insurance coverage at the time the person was initially eligible to enroll.
- At the time, the employee (Subscriber) of the Group was first eligible to enroll, the employee stated, that the employee and/or eligible Dependents were not enrolling because of such other coverage. The employer may require this in writing.
- The person’s coverage under the other plan or insurance:
 - Was under a Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 continuation provision and the coverage under that provision was exhausted (and not voluntarily terminated).
 - Was not under a COBRA continuation period and either the coverage was terminated as a result of loss of eligibility or employer contributions toward the coverage were terminated.



You must submit a signed Application with any required Prepayment within **31 days** of the date coverage was terminated either under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, or the date the other coverage (or the other employer’s contribution toward Coverage) was terminated.

If the Subscriber and/or Dependent does not enroll during the **31-day** Special Enrollment period, enrollment in our Coverage can occur only during a subsequent Annual Group Enrollment Period.



There are no Special Enrollment periods for you or your Dependents who apply for Continuation, Conversion Coverage or Extension of Benefits. You must apply for and enroll in the Coverage within the time limit required for each Coverage. Refer to **each of these Sections** for information on each Coverage.

Other Special Enrollment Periods

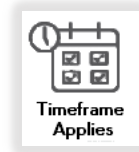
- **Dependent eligibility for special enrollment periods:** A qualified individual’s dependent may be eligible for a special enrollment period because of a relationship to a qualified individual enrollee.

- **Special enrollment period for foster placement:** Placement of a foster child is a triggering event for a special enrollment period.
- **Special enrollment period coverage effective dates:** Presbyterian is required to ensure coverage effective dates for special enrollments due to birth, adoption and foster care placement on the date of the triggering event. In cases of special enrollments due to marriage or loss of minimum essential coverage, the Plan must ensure coverage effectuation on the first day of the following month. Plans are otherwise required to ensure that coverage obtained during a special enrollment period is effective on an appropriate date based on the circumstances of the special enrollment period.
- **Special enrollment period for “exceptional circumstances:”** Presbyterian may allow special enrollment periods for exceptional circumstances.

CHIPRA Special Enrollment Period and Qualifying Event (Children’s Health Insurance Program Reauthorization Act)

In accordance with the Children’s Health Insurance Program (CHIP) provisions as currently defined under federal law, you and/or your eligible Dependents who are not currently enrolled in our Coverage, may enroll in our Plan. There are two circumstances when this CHIPRA Special Enrollment Period may apply.

- **Loss of Medicaid/CHIP Eligibility:**
 - If you, as an eligible Subscriber, chose not to enroll in our Coverage for yourself and/or Dependent(s) during a previous enrollment period because you and/or your Dependent(s) were covered under a state Medicaid or Children’s Health Insurance Program (CHIP) plan, the person who loses Medicaid/CHIP eligibility may enroll in our Coverage. If you, as an eligible Subscriber, are not enrolled for Coverage, you must enroll in our Coverage at the same time as your Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of the date Medicaid or CHIP coverage terminated.
 - You must submit a completed, signed Application within **60 days** of the loss of Medicaid or CHIP coverage. We will require documentation from the State supporting the fact that the person who had the Medicaid/CHIP Coverage lost the Coverage voluntarily. Coverage will start no later than the first day of the month after we receive your Application and any required Prepayment.
 - If you, as Subscriber, lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and your Dependents, including your Spouse. If your Dependent lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and that Dependent (not to other Dependents).



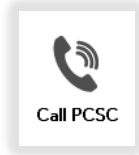
Full, Accurate and Complete Information

You, as a Subscriber, must fully and accurately complete and sign an Application for Coverage as required. False or fraudulent statements or intentional misrepresentations of material fact provided in an Application may result in the Termination of all Coverage for you and your Dependents.

A retroactive Termination of Coverage or rescissions (back to the initial date of enrollment) for fraud or intentional misrepresentation of material fact, except for those attributable to failure to pay prepayments, premiums or contributions may occur. This rule does not apply to prospective Termination of Coverage.

We will provide at least **30 days** advance written notice to each participant who would be affected prior to rescinding coverage.

Change in Address, Family Status and Employment

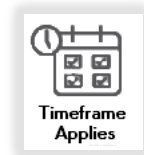


Changes in your Dependents, marital status, employment or address may affect your Coverage under this Plan. Please notify your Employer Group's human resources office and ask that they notify us of all changes. You may notify us directly by calling our Presbyterian Customer Service Center at **(505) 923-6980** or **1-800-923-6980**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Or visit our website at www.phs.org.

Termination of Coverage

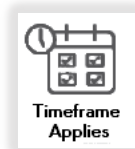
The Employer Administrative Services Agreement (ASA) shall be cancelled and shall terminate in the event any one of the following conditions occurs:

- **Termination of the Employer Group for Non-payment:**
 - In the event any Premium, including a Prepayment and any applicable finance charge or charges, is not paid to us when it is due from the Group, we shall notify and mail a Notice of Cancellation to the Group within **30 days**. The Group shall then immediately forward to each Subscriber, by first-class mail at his or her current address, a legible copy of such notice. Termination of this Plan shall not become effective sooner than **30 days** after the date the notice is hand delivered or mailed to each Subscriber.
 - If we receive payment of the Premium (including any Prepayment and all other applicable amounts and charges) within **15 days** of the issuance of the Notice of Cancellation, it shall be sufficient to prevent cancellation and termination under this paragraph. If we do not receive payment of such charge within this **15-day period**, we may, at our option, either:
 - Require that a new Application for Coverage be submitted, notifying the Group of the conditions under which a new Contract will be issued or the original Application reinstated; or
 - Elect to abide by this cancellation by returning to the Group, within **20 business days** after receipt, any Prepayment for Coverage for periods after the effective date of cancellation.
 - Cancellation and termination of this Plan under this paragraph shall become effective as of the last date of Prepayment. We shall be entitled to recover from the Group or from the Subscriber any and all payments for Covered Benefits



made on behalf of any Subscriber or the Subscriber's Dependent(s) after the last date of the period for which Prepayment was received.

- **Voluntary Termination by the Employer Group of the Administrative Services Agreement (ASA):**
 - Voluntary Termination of Coverage by the Group is governed by the terms of the ASA. Such termination shall only be effective as of the last day of the month.
- **Our Termination of your Employer Group:**
 - Our termination of the Group is governed by the terms of the ASA and is in accordance with federal and state laws. Our termination or cancellation of the Group shall automatically terminate this Plan. Upon our cancellation or termination of our Contract with the Group, the Group shall promptly mail a legible copy of the Notice of Cancellation to each Subscriber at the Subscriber's current address and shall promptly provide us with proof of such mailing and the date thereof.
 - Such cancellation shall become effective no sooner than **30 days** after the date the Group mails the notice to Subscribers. The notice requirement in this paragraph does not apply to our refusal to renew any ASA that does not contain an automatic renewal provision.
- **Termination of your Summary Plan Description (Plan):**
 - This Plan shall be cancelled and your (Subscriber and Dependent) Coverage shall terminate in the event any one of the following conditions occurs:
 - We will not terminate your Coverage for nonpayment of Cost Sharing amounts during any period in which you are Hospitalized and receiving treatment for a life-threatening condition. In addition, we will not terminate your Coverage for refusal to follow any prescribed course of treatment.
 - False Material Information/Rescissions:
 - On the date we specify, this Plan will terminate if you (the Subscriber) have knowingly given false material information in connection with your eligibility or enrollment of yourself or any of your Dependents, provided we send written notice to you (the Subscriber) at least **30 days** in advance of such termination. In such case we, at our sole discretion, may terminate Coverage for you and all of your Dependents, and may make such termination effective retroactively as of the date of enrollment. You shall be responsible for payment for all Healthcare Services rendered hereunder as of the effective date of such termination and shall reimburse us for all such Healthcare Benefit payments that we made on your behalf or on behalf of any of your Dependents.
 - Military Service:
 - Coverage for you (Subscriber) and your eligible Dependents will terminate at the end of the month during which you entered into active military duty (except for temporary duty of **30 days** or less).



- At the end of the Contract month in which you (the Subscriber) cease to physically live within the State of New Mexico or work for an employer headquartered in the State of New Mexico, our Service Area. Coverage for all Dependents will terminate on the same date as your (the Subscriber's) coverage.
- At the end of the Contract month in which you cease to be eligible as a Subscriber or Dependent.
- On the date that adoption placement for the child originally placed for adoption, is disrupted prior to legal adoption, and is removed from placement.
- As of the date on which you permit the use of our Identification Card by any other person, we may, at our discretion, terminate Coverage for you and for all Members of your family. We must send written notice to you (Subscriber) at least **30 days** in advance of such termination.
- If two or more Practitioners/Providers, after a reasonable effort, are unable to establish and maintain a satisfactory Practitioner/Provider-patient relationship with you or any of your Dependents, then the rights of that Member under this Plan may be terminated provided we send written notice to you (Subscriber) at least **30 days** in advance of such termination.

In the event that premiums owed to us has remained unpaid through the grace period allowed for the payment, Presbyterian will be liable for valid claims for Covered losses prior to the grace period except that Presbyterian will be entitled to the premium due for coverage provided during the grace period. As required by state regulation enforced by the New Mexico Division of Insurance, Members Covered under our contract with any employer group must be notified a minimum of **30 days** prior to loss of coverage. If payment in full is not received by the deadline, Presbyterian will notify your Covered employees, adhering to the **30-day** notification requirement and you will be responsible for an additional month of premium. Presbyterian will not recognize claims incurred after the end of the grace period if premiums remain unpaid.

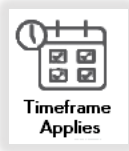
If you or any of your Dependents are terminated for Good Cause, as defined in the **Glossary of Terms Section**, then you or any of your Dependents are not eligible for COBRA continuation or Individual Conversion.

We will not terminate Coverage under this Plan for any Member based solely upon the Member's health status, requirements for Healthcare Service, race, gender, age, sexual orientation, or for refusal to follow a prescribed course of treatment. If you or your Covered Dependents believe that Coverage was terminated due to health status or healthcare requirements.

Unless we agree, in writing, no Covered Benefits shall be provided under this Plan following the date this Plan terminates including, but not limited to, when you or your Covered Dependent remains in the Hospital after the date of termination of this Plan.

We shall be entitled to recover from you (Subscriber) any and all payments for Covered Benefits made on behalf of you or your Dependents after the last date this Plan was in force.

Notice of Termination to Members



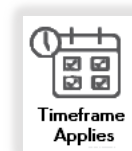
If this Plan is terminated for cause, we will send a Notice of Cancellation to you (the Subscriber) no less than **30 days** prior to the effective date of termination.

- The notice will be dated
- State the reason(s) for termination
- Provide information about your ability to enroll in a conversion plan
- Include other matters required by law, including information related to premium refunds, if any, and reinstatement

Continuation of Coverage of Your Group Plan

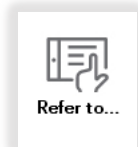
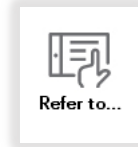
If your Coverage would otherwise terminate because of a loss of eligibility as a Subscriber or Dependent, you may be entitled to continue your Coverage under one of the following options:

- **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985**
 - Most Employer Groups with 20 or more employees are required to offer continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.
 - If you lose eligibility for Coverage and if you are entitled to COBRA Coverage, you may continue your Coverage as a Member of the Employer Group under this Plan and in accordance with the ASA for the period of time allowed under COBRA unless and until:
 - You terminate your Coverage.
 - Your Coverage under this Plan is terminated for Good Cause.
 - You fail to make a timely election for COBRA Coverage.
 - You fail to make timely payments for your COBRA Coverage.
 - You become Covered under another Group Healthcare Plan.
 - You become entitled to Medicare benefits.
 - Members have the choice of whether to enroll in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease "ESRD".
 - Your Group's benefit administrator will provide you with information about your eligibility for COBRA. If you are eligible, you (the Subscriber) or your eligible Dependent must elect COBRA Coverage within **60 days** of the date you lose eligibility for Coverage under this Plan. Your COBRA Coverage will be effective only if we receive your COBRA Application within **60 days** after the date your Group Coverage under this Plan terminates.
 - If you or your eligible Dependent elects COBRA Coverage and submits your Application, you will have **45 days** from the date of the election to pay the initial

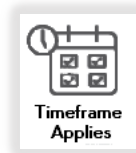


Prepayment due. All subsequent Prepayments will be paid on a monthly basis. There is a **30-day** grace period to pay Prepayments. If the Prepayment is not paid before the expiration of the grace period, COBRA continuation benefits will end.

- Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for COBRA continuation.
- **State Continuation of Group Coverage**
 - Employer groups with fewer than 20 active employees (or otherwise not required to offer COBRA continuation) may provide continuation of non-COBRA Coverage.
 - You, on behalf of yourself and your Dependent(s), upon termination of employment with the Employer Group, have the right to continue your Group Coverage for six months under state law. At the end of the six months, you may convert your Coverage to the individual conversion option that we offer, in accordance with the **non-Group Coverage Section**.
 - An enrolled Dependent, upon loss of eligibility for Coverage under this Plan (following the continuation of Group Coverage for six months under state law), may have the option of converting the Group Coverage to the individual conversion option we offer. The circumstances and conditions under which conversion is allowed are specified in the **non-Group Coverage Section**.
 - Coverage under this State Continuation option will terminate prior to the end of the six-month period of Coverage in the event:
 - You terminate your Coverage.
 - Your Coverage under this Plan is terminated for Good Cause.
 - You fail to make a timely election for continuation Coverage.
 - You fail to make timely payments for your continuation Coverage.
 - You become Covered under another Group health plan.
 - You become entitled to Medicare benefits.
 - Members have the choice of whether to enroll in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease "ESRD".
 - State continuation Coverage is effective only if we receive your continuation Application and the applicable Prepayment within **31 days** after the date your Group Coverage under this Plan terminates.
 - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for state continuation Coverage.
- **Eligibility for Individual Conversion Option**
 - If you are still Covered by Presbyterian Insurance Company at the expiration of any continuation period (whether under COBRA or state law), you will have the option of converting your continuation Coverage to the Individual Conversion Option we provide in accordance with the provisions of the **non-Group Coverage Section**.
 - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for COBRA continuation, state continuation or non-Group/Individual Conversion Option.



- **Conversion to non-Group Coverage (Individual Conversion Option)**
 - You may be eligible to enroll in non-Group coverage as follows:
 - You (on behalf of yourself and your enrolled Dependents) shall have the right to convert to a non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon exhausting the benefits of the COBRA or state continuation coverage.
 - An enrolled Dependent Member under this Plan shall have the right to convert to a separate, non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon termination of the Dependent's benefit period under COBRA or state continuation, if any.
 - When your (Subscriber) Dependent Spouse elects Conversion coverage, the Dependent Spouse may include coverage for Dependent children for whom the Dependent Spouse has responsibility for care and support.
 - At the time of Conversion, the Individual Conversion or non-Group coverage provided shall be your choice of one of our available policies. However, at the time of Conversion, if you or your eligible Dependent are eligible for Medicare, the right to convert may be limited to coverage under a Medicare Supplemental Insurance Contract, which are available from other carriers.
 - Individual Conversion Coverage is effective only if we receive your Individual Conversion Application and the applicable Prepayment within **60 days** after the date your Group Coverage under this Plan terminates.
 - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for the Individual Conversion Option.
 - You, as the Subscriber, may terminate Individual non-Group Membership Coverage with no less than **30 days** written notice.
- **Extension of Benefits for the Totally Disabled**
 - In the event you are totally disabled on the date your Group Coverage terminates, healthcare Coverage may be continued for up to 12 consecutive months. To claim an extension of benefits, you must notify us within **31-days** of the Group Coverage termination date and provide evidence of your total disability.
 - For purposes of this section, totally disabled means that an individual is prevented, solely because injury or disease, from performing their regular or customary occupational duties or is incapable of doing most of the normal activities and tasks for that person's age and family status. In order to qualify for benefits under this extension, you must have been totally disabled on the date that the Group Coverage terminates, incur an expense directly resulting from that particular disability and such expense would have been a Covered Benefit before termination.



Our Responsibility When Your Group Contract is Replaced

In the event that your contract with another carrier is replaced by Presbyterian due to the prior carrier's discontinuance of the contract, you will be eligible and Covered for benefits under this Plan according to the eligibility requirements of this Plan and your employer. Persons not

eligible for coverage under this Plan will be Covered by Presbyterian if the individual was Covered under the previous carrier's plan on the date of discontinuance and if the individual is a member of the class of individuals eligible for coverage under this Plan. Coverage provided will be according to the level of benefits described under this Plan reduced by any benefits payable by the prior plan. Benefits will be provided by Presbyterian until the earliest of the following dates: the date the individual becomes eligible under this Plan and their employer, or the date the individual's benefits would terminate in accordance with termination provisions under this Plan. Conversion privileges will be granted to those individuals whose benefits cease. Presbyterian shall give credit for the satisfaction or partial satisfaction for any Deductibles, Coinsurance, Copayments, or waiting periods that were satisfied under the prior plan providing similar benefits. The credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the Deductible provision of the prior carrier's plan during the **90 days** preceding the effective date of this plan, but only to the extent these expenses are recognized under the terms of this Plan and are subject to a similar Deductible provision. In any situation where a determination of the prior carrier's benefit is required by Presbyterian, Presbyterian will request the prior carrier to furnish a statement sufficient to permit verification of the benefit determination. The benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of Presbyterian. This determination will be made as if coverage had not been replaced by Presbyterian.

Discontinuance of Your Plan

In the event that Presbyterian Insurance Company (PIC) decides to discontinue offering this plan, PIC will provide a notice to you at least **90 days** prior to the date of discontinuing the coverage. You will be offered other available coverage PIC offers in the market. In the event that PIC decides to discontinue all coverage in the market, PIC will notify you of this at least 180 days prior to the date of discontinuance.

Guaranteed Renewability

An issuer may non-renew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:

- **Non-payment of Premiums** - The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.
- **Fraud** - The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
- **Violation of Participation or Contribution rules** – In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law. For purposes of this paragraph the following apply:
 - (i) The term “employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

- (ii) The term “group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.
- **Termination of product** – The issuer is ceasing to offer coverage in the market in accordance with paragraph *Discontinuing a particular type of coverage or Discontinuing all coverage* section and applicable State law.
 - **Enrollees' movement outside of the service area** - For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; provided the issuer provides notice in accordance with the requirements of *Discontinuing a particular type of coverage* section.
 - **Association membership ceases** - For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.
 - **Discontinuing a particular type of coverage** – An issuer may discontinue offering a particular type of health insurance coverage offered in the individual market only if it meets the following requirements:
 - (1) Provides notice in writing, in a form and manner specified by the Secretary, to each individual provided coverage of that type of health insurance at least 90 calendar days before the date the coverage will be discontinued.
 - (2) Offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market.
 - (3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
 - **Discontinuing All Coverage** – An issuer may discontinue offering all health insurance coverage in the individual market in a State only if it meets the following requirements.
 - (1) Provides notice in writing to the applicable State authority and to each individual of the discontinuation at least 180 days before the date the coverage will expire.
 - (2) Discontinues and does not renew all health insurance policies it issues or delivers for issuance in the State in the individual market.
 - (3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
 - (4) For purposes of this section, subject to applicable State law, an issuer will not be considered to have discontinued offering all health insurance coverage in a market in a State if -
 - (i) The issuer (in this paragraph referred to as the initial issuer) or, if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, offers and makes available in the applicable market in the State at least one product that is considered in accordance with 45 CFR § 144.103 of

this subchapter to be the same product as a product the initial issuer had been offering in such market in such State; or

(ii) The issuer -

(A) Offers and makes available at least one product in the applicable market in the State, even if such product is not considered in accordance with 45 CFR § 144.103 of this subchapter to be the same product as a product the issuer had been offering in the applicable market in the State;

(B) Subjects such new product or products to the applicable process and requirements established under 45 CFR Part 154 of this title as if such process and requirements applied with respect to that product or products, to the extent such process and requirements are otherwise applicable to coverage of the same type and in the same market; and

(C) Reasonably identifies the discontinued product or products that correspond to the new product or products for purposes of the process and requirements applied pursuant to paragraph of this section.

(5) For purposes of this section, the term, *controlled group*, means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended, or a narrower group as may be provided by applicable State law.

- **Prohibition on market reentry** – An issuer who elects to discontinue offering all health insurance coverage under *Discontinuing all coverage* section may not issue coverage in the market and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.
- **Exception for uniform modification of coverage** –
 - (1) An issuer may, only at the time of coverage renewal, modify the health insurance coverage for a product offered in the individual market if the modification is consistent with State law and is effective uniformly for all individuals with that product.
 - (2) For purposes of *Discontinuing all coverage* of this section, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:
 - (i) The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and
 - (ii) The modification is directly related to the imposition or modification of the Federal or State requirement.
 - (3) For purposes of this section, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:
 - (i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act), or if the issuer that is a member of a controlled group (as described in *Discontinuing all coverage* section), any other health insurance issuer that is a member of such controlled group;
 - (ii) The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

- (iii) The product continues to cover at least a majority of the same service area;
- (iv) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and
- (v) The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the rate for any plan within the product within an allowable variation of ± 2 percentage points (not including changes pursuant to applicable Federal or State requirements).

(4) A State may only broaden the standards in paragraphs (iii) and (iv) of this section.

- **Application to coverage offered only through associations** - In the case of health insurance coverage that is made available by a health insurance issuer in the individual market only through one or more associations, any reference in this section to an “individual” is deemed to include a reference to the association of which the individual is a member.
- **Notice of renewal of coverage** - If an issuer is renewing grandfathered coverage as described in *General rules* of this section, or uniformly modifying grandfathered coverage as described in *Exception for uniform modification of coverage* of this section, the issuer must provide to each individual written notice of the renewal at least 60 calendar days before the date the coverage will be renewed in a form and manner specified by the Secretary.

General Provisions

This Section explains important information and provisions not covered in other sections of this Plan.

Amendments (Group)

This Summary Plan Description (Plan) and the Administrative Services Agreement (ASA) shall be subject to amendment, modification, or termination in accordance with their provisions or by mutual agreement in writing between us and the Group. By electing Coverage or accepting benefits under this Plan you and all Members legally capable of contracting, agree to all the terms, conditions, and provisions of this Plan and the ASA.

Assignment

All your rights to receive benefits and services are personal and may not be assigned.

Entire Contract

This Plan, the *Summary of Benefits and Coverage*, any amendments, Endorsements, supplements or riders, the ASA or the non-Group Membership Letter of Agreement, the Employee Action Form and/or Universal/Uniform Medical Assessment Form (Application) completed upon enrollment (if applicable) by the Subscriber Covered hereunder and our issued Identification Card constitute the entire Contract between the parties and, as of the effective date hereof, supersede all other Plans between the parties.

Execution of Contract - Application for Coverage

The parties acknowledge and agree that your signature or execution of the Application shall be deemed to be your acceptance of the Contract, including the ASA and this Plan. All statements, in the absence of fraud, made by any applicant (you and/or your Dependents) shall be deemed representations and not warranties. No such statements shall void Coverage or reduce benefits unless contained in a written Employee Action Form and/or Uniform Medical Assessment Form, which is an Application for Coverage.

Federal and State Healthcare Reform

We shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects our obligations under this Plan, this Plan will be deemed automatically amended such that we shall remain in compliance with the obligations imposed by such law, rule or regulation.

Fraud

We are required to cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Practitioner/Provider activity and Member activity.

Practitioner/Provider Activity

If you suspect that a Practitioner, pharmacy, Hospital, facility or other Healthcare Professional has done any of the items listed below, please call the Practitioner or Provider and ask for an explanation. There may be an error.

- Charged for services that you did not receive
- Billed more than one time for the same service
- Billed for one type of service, but gave you another service (such as charging for one type of equipment but delivering another less expensive type)
- Misrepresented information (such as changing your diagnosis or changing the dates that you were seen in the office)

If you are unable to resolve the issue, or if you suspect any other suspicious activity, please contact our Special Investigative Unit (SIU) hotline at **(505) 923-5959** or **1-800-239-3147**. This confidential voicemail box is available **24 hours** a day. Any information you provide will be treated with strict confidentiality. When reporting suspected health insurance fraud, you may remain anonymous. You can also contact the SIU via email at:

Address: Presbyterian Insurance Company, Inc.
Special Investigative Unit (SIU)
P.O. Box 26267
Albuquerque, NM 87125-6267

Email: PHPFraud@phs.org

Online: <https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/form>

Member Activity

Anyone who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate enrollment for any Member for any type of fraudulent activity. Some examples of fraudulent activity are:

- Falsifying enrollment information
- Allowing someone else to use your ID Card
- Forging or selling prescriptions
- Misrepresenting a medical condition in order to receive Covered Benefits to which you would not normally be entitled

Governing Law

This Plan is made and shall be interpreted under the laws of the State of New Mexico and applicable federal rules and regulations.

Identification Cards

We issue Identification (ID) Cards to you, pursuant to the ASA, for identification purposes only. Possession of our ID Card confers no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the ID Card must, in fact, be a Member on whose behalf all applicable Premium have actually been paid. If you or any family Member permits the use of your ID Card by any other person, all your rights and other Members of your family pursuant to this Plan may be immediately terminated at our discretion. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Contract shall be charged therefore at the rates generally charged in the area for medical, Hospital and other Healthcare Services.

Legal Actions

No action at law or in equity shall be brought to recover on this Plan by the Group or a Member prior to the expiration of **60 days** after written proof of loss has been furnished, in accordance with the requirements of this Plan. No such action shall be brought after the expiration of **three years** after the time written proof of loss is required to be furnished.

Misrepresentation of Information

If, in the first **two years** from the effective date of your and/or your Dependents Coverage, we determine that you intentionally omitted information from your Employee Action Form, the Universal/Uniform Medical Assessment form or other Coverage Application and/or you provided fraudulent or false information, the Coverage for you and/or your Dependent shall be null and void from the effective date. In the case of fraud, no time limits shall apply, and you will be required to pay for all benefits that we have provided.

Misstatements

No misstatements, except fraudulent misstatements, made by the applicant in the Employee Action Form, the Universal/Uniform Medical Assessment Form or other Application for Coverage for this Contract shall be used to void the Contract or to deny a claim for loss incurred or disability (as defined in this Summary Plan Description).

Notice

If we are required or permitted by this Plan to give any Notice to the Group, Subscriber or Member, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to the Group, Subscriber or Member at the address of record on file at our principal office. The Group is solely responsible for

ensuring the accuracy of its addresses and the Subscriber and/or Member is solely responsible for ensuring the accuracy of his/her address of record on file with us.

Policies and Procedures

We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan.

Reinstatements

We may reinstate this Plan after termination without the execution of a new Application or the issuance of a new Identification Card or any notice to the Subscriber or Member, other than the unqualified acceptance of an additional payment from the Group or Remitting Agent.

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurance company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurance company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurance company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Right to Examine

We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Waiver by Agents

No agent or other person, except an officer of Presbyterian Insurance Company has the authority to waive any conditions or restrictions of this Plan, to extend the time for making payment, or to bind Presbyterian Insurance Company by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an Endorsement or amendment in writing to this Plan or the applicable ASA or non-Group Membership Letter of Agreement signed by one of the aforesaid officers.

Workers' Compensation Insurance

This Plan is not in lieu of and does not affect any requirement for Coverage by the New Mexico Workers Compensation Act. However, an employee of a professional or business corporation may affirmatively elect not to accept the provisions of the New Mexico Workers Compensation Act. More specifically, an employee may waive workers' compensation Coverage provided that the following criteria have been met:

- The "employee" is an executive officer of a professional or business corporation; and
- The "employee" owns 10 percent (**10%**) or more of the outstanding stock of the professional or business corporation.

For purposes of the New Mexico Workers Compensation Act, an "executive officer" means the chairperson of the board, president, vice-president, secretary or treasurer of a professional or business corporation.

In the event that an employee chooses to opt out of workers' compensation Coverage, and meets the criteria as stated above, PIC will provide 24-hour healthcare Coverage to those employees, subject to the eligibility requirements for Coverage with PIC. In addition to meeting all of PIC's eligibility requirements, documentation indicating that the aforementioned criteria have been met will be required in order for Coverage with PIC to become effective.

Glossary of Terms

This Section defines some of the important terms used in this Plan. Terms defined in this Section will be capitalized throughout the Plan.

Accidental Injury means a bodily injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia or cerebral vascular accident. Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury.

Acupuncture means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

Acute Medical Detoxification is a form of drug and alcohol abuse treatment in which a patient is weaned off their alcohol or drug addiction immediately with the help of medical supervision. It is a serious medical process that usually takes **three to five days**, depending on the substance.

Administrative Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding any aspect of a Health Benefits Plan other than a request for Healthcare Services, including but not limited to:

- Administrative practices of the Healthcare Insurer that affects the availability, delivery, or quality of Healthcare Services
- Claims payment, handling or reimbursement for Healthcare Services
- Terminations of Coverage

Administrative Services Agreement (ASA) means the administrative agreement between us and the Group.

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Adverse Determination Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding an Adverse Determination.

Agreement means including supplements, Endorsements or riders, if any.

Alcoholism means alcohol dependence or alcohol use disorder meeting the criteria as stated in the (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013).

Ambulance Service means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

Annual Group Enrollment Period means a period of at least **ten working days** prior to the expiration of each Contract Year mutually agreed to by our company and the Group, during which eligible Subscribers are given the opportunity to enroll themselves and their eligible Dependents under the Plan without providing satisfactory evidence of good health.

Annual Out-of-pocket Maximum means a specified dollar amount of Covered Services received in a Contract Year that is the most the Member will pay (Cost Sharing responsibility) for that Contract Year.

Appeal means a request from a Member, or their representative, or a Practitioner/Provider who is representing a Member, to Presbyterian Insurance Company for a reconsideration of an Adverse Determination (denial, reduction, suspension or termination of a benefit).

Application means the forms, including the Employee Action Form and required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for our Coverage.

Authorized means **Prior Authorization** was obtained (when required) prior to obtaining Healthcare Services both In-network and Out-of-network.

Authorization means a decision by a Healthcare Insurer that a Healthcare Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Healthcare Insurer's requirements for Coverage and Medical Necessity, and the requested Healthcare Service is therefore approved. See **Certification**.

Autism Spectrum Disorder means a condition that meets the diagnostic criteria for the pervasive development disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, including Autistic Disorder; Asperger's Disorder; Pervasive Development Disorder not otherwise specified; Rett's Disorder; and Childhood Disintegrative Disorder.

Balance Billing means when a Provider bills you for the difference between the Provider's charge and the allowed amount. For example, if the Provider's charge is \$100 and the allowed amount is \$70, the Provider may bill you for the remaining \$30. A preferred Provider may not balance bill you for covered services.

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition.

Biosimilar Drug is a biological product that is highly similar to an existing FDA approved product. It has no meaningful difference in terms of safety, purity, and potency.

Calendar Year means the period beginning January 1 and ending December 31 of the same year.

Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection or treatment of cancer that is being provided in New Mexico.

Cardiac Rehabilitation means a program of therapy designed to improve the function of the heart.

Certification of Service means a determination by a health insurance carrier that a healthcare service requested by a healthcare professional or covered person has been reviewed and, based upon the information available, is a covered benefit and meets the carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care and effectiveness, and the requested healthcare service is therefore approved. The certification of service can take place following the health carrier's utilization review process.

Certified Nurse Midwife means any Person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse-Midwife.

Certified Nurse Practitioner means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the board of nursing.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of

those people to affect the dependent Person (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013).

Coinsurance is a Cost-Sharing method that requires a covered person to pay a stated percentage of medical or pharmaceutical expenses after the deductible amount, if any, is paid; co-insurance rates may differ for different types of services under the same health benefits plan.

Complaint means the first time we are made aware of an issue of dissatisfaction that is not complex in nature. For more complex issues of dissatisfaction see definition for **Grievance**.

Continuous Quality Improvement means an ongoing and systematic effort to measure, evaluate and improve a health insurance carrier's processes and procedures in order to continually improve the quality of Healthcare Services provided to covered persons.

Contract means the Application submitted as the basis for issuance of this Summary Plan Description (Plan). This Plan including the *Summary of Benefits and Coverage*, any supplements, Endorsements or riders, the Application, medical questionnaire (if applicable), the issued Identification Card, and the applicable Administrative Services Agreement or non-Group Membership Letter of Agreement constitute the entire Contract.

Contract Year means the period, or other length of time covered by the Contract, that we and the Group mutually agree to, as specified in the Administrative Services Agreement (ASA).

Conversion Subscriber means a Member who has converted to our non-Group (Individual Conversion) Membership as a Subscriber, pursuant to the Continuation of Coverage Section.

Copayment is a Cost-Sharing method that requires a covered person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the Health Insurance carrier paying the allowed balance; there may be a different Copayment amounts for different types of services under the same Health Benefits Plan.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Cost Sharing means a Copayment, Coinsurance, Deductible, or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the health benefits plan.

Coverage/Covered means benefits extended under this Plan, subject to the terms, conditions, limitations, and exclusions of this Plan.

Covered Benefits means those healthcare services to which a covered person is entitled under the terms of a health benefits plan.

Covered Person or Enrollee means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

Craniomandibular means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

Culturally and Linguistically appropriate manner of notice means the notice that meets the following requirements:

- The Healthcare Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language.
- The Healthcare Insurer must provide, upon request, a notice in any applicable non-English language.
- The Healthcare Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Healthcare Insurer.

For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent (**10%**) or more of the population residing in the county is literate only in the same non-English language, as determined by the Department of Health and Human Services (HHS). The counties that meet this 10 percent (**10%**) standard, as determined by HHS, are found at <http://cciiio.cms.gov/resources/factsheets/clas-data.html> and any necessary changes to this list are posted by HHS annually.

Custodial or Domiciliary Care means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's normal daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

Cytologic Screening (PAP Smear) means a Papanicolaou test or liquid based cervical cytopathology, a Human Papillomavirus Screening test and a pelvic exam for symptomatic as well as asymptomatic female patients.

Deductible means a fixed dollar amount that a Covered person may be required to pay during a benefit period before the health insurance carrier begins payment for Covered benefits; health benefits plans may have both individual and family Deductibles and separate Deductibles for specific services.

Dependent means any Member of a Subscriber's family who meets the requirements of the **Eligibility, Enrollment and Effective Dates Section** of this Plan, who is enrolled as our Member.

Diagnostic Breast Examination means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

- seen or suspected from a screening examination for breast cancer; or
- detected by another means of examination.

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Doctor of Oriental Medicine means a person licensed as a physician to practice acupuncture and oriental medicine with the ability to practice medicine and collaborate with other healthcare providers. A doctor of Oriental Medicine may serve as a Primary Care Practitioner provided that they are 1) acting within his or her scope of practice as defined under the relevant state licensing law; 2) meets the PIC eligibility criteria for healthcare practitioners who provide primary care; and 3) agrees to participate and to comply with PIC's care coordination and referral policies.

Durable Medical Equipment means equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

Emergency Care means healthcare procedures, treatments, evaluations, or services delivered to a Covered Person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Reasonable Layperson, to result in:

- Jeopardy to the person's physical or mental health
- Safety of a fetus or pregnant person
- Serious impairment of bodily functions
- Serious dysfunction of any bodily Organ or part
- Disfigurement to the person

Emergency Medical Condition means an illness, injury, symptom or condition that is so serious that a Reasonable/Prudent Layperson, who is without medical training and who uses his

or her experience and knowledge when deciding whether or not to seek Emergency Health Care Services would seek care right away to avoid severe harm. Refer to **Reasonable/ Prudent Layperson** definition in this Glossary.

Endorsement means a provision added to the Summary Plan Description that changes its original intent.

Enrollee or Covered Person means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

Evidence-based Medical Literature means only published reports and articles in authoritative, peer-reviewed medical and scientific literature.

Excluded Services means Healthcare Services that are not Covered Services and that we will not pay for.

Experimental or Investigational medical, surgical, other healthcare procedures or treatments, including drugs. As used in this Plan, "Experimental" or "Investigational" as related to drugs, devices, medical treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated does, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by State law, the drug or device is used for a purpose that is not approved by the FDA; or
- For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in State law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, "Experimental" or "Investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

Eye Refraction means the measurement of the degree of refractive error of the eye by an eye care specialist for the determination of a prescription for eyeglasses or contact lenses.

Fabricated Orthosis means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

Family, Infant and Toddler (FIT) Program means an early intervention services program provided by the Healthy Family and Children's Healthcare Services to eligible children and their families.

FDA means the United States Food and Drug Administration.

Formulary A drug *Formulary*, or preferred drug list, means the list of prescription drugs covered by a policy, plan, or certificate of health insurance, and the tier level at which each drug is Covered under this Plan. Presbyterian Insurance Company, Inc.'s Pharmacy and Therapeutics Committee continually update this listing. For the most up-to-date *Formulary* drug information visit <https://client.formularynavigator.com/Search.aspx?siteCode=0324498195>.

Generic Drug is a drug approved by the FDA as having the same active ingredient and may be substituted for the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder if that person has a known family history or classic symptoms of a disorder.

Genetic Inborn Errors of Metabolism (IEM) means a rare, inherited disorder that is present at birth and results in death or mental disability if untreated and requires consumption of Special Medical Foods. Categories of IEMs are as follows:

- Disorders of protein metabolism (i.e., amino acidopathies such as PKU, organic acidopathies, and urea cycle defects)
- Disorders of carbohydrate metabolism (i.e., carbohydrate intolerance disorders, glycogen storage disorders, disorders of gluconeogenesis and glycogenolysis)
- Disorders of fat metabolism

Good Cause means nonpayment of premium, fraud or a cause for cancellation or a failure to renew which the Superintendent of Insurance of the state of New Mexico has not found to be objectionable by regulation.

Grievance means any expression of dissatisfaction from any Member, the Member's Representative, or a Practitioner/Provider representing a Member.

Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or Practitioner/Provider, acting on behalf of that person with that person's consent, entitled to receive healthcare benefits provided by the healthcare plan.
- An individual, or that person's authorized representative, who may be entitled to receive healthcare benefits provided by the healthcare plan.
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Healthcare Purchasing Act.

Group means the legal entity which has contracted with us to obtain the benefits described in this Plan for Subscribers and eligible Dependents, called Members, in return for periodic Prepayments specified in the Administrative Services Agreement (ASA).

Habilitative Services means services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally.

Health Benefits Plan means a policy or Plan entered into, offered or issued by a Health Insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare Services.

Healthcare Facility means an institution providing Healthcare Services, including a Hospital or other licensed Inpatient center; an ambulatory surgical or treatment center; a Skilled Nursing Facility; a Residential Treatment Center, a Home Health Agency; a diagnostic laboratory or imaging center; and a Rehabilitation Facility or other therapeutic health setting.

Healthcare Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit healthcare plan, fraternal benefit society, vision plan, or pre-paid dental plan.

Healthcare Professional means a physician or other healthcare Practitioner, including a pharmacist or practitioner of the healing arts, who is licensed, certified or otherwise authorized by the state to provide Healthcare Services consistent with state law. See **Practitioner**.

Healthcare Services means a service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, to the extent covered by the health benefits plan, a physical or behavioral health service.

Hearing Aid means Durable Medical Equipment that is of a design and circuitry to optimize audibility and listening.

Hearing Officer, Independent Co-Hearing Officer or ICO means a healthcare or other professional licensed to practice medicine or another profession who is willing to assist the

Superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and Coverage issues that arise in external review hearings.

Home Health Agency means a facility or program, which is licensed, certified or otherwise authorized pursuant to state laws as a Home Health Agency.

Home Health Care Services means Healthcare Services provided to a Member confined to the home due to physical illness. Home Health Care Services and home intravenous services and supplies will be provided by a Home Health Agency at a Member's home when prescribed by the Member's Practitioner/Provider and we approve a **Prior Authorization** request for such services.

Hospice means a duly licensed facility or program, which has entered into an agreement with us to provide Healthcare Services to Members who are diagnosed as terminally ill.

Hospital means a facility offering inpatient services, nursing and overnight care for three or more individuals on a **24-hours-per-day, seven-days-per-week** basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

Human Papillomavirus Screening means a test approved by the Federal Food and Drug Administration for detection of the Human Papillomavirus.

Identification Card (ID or Card) means the card issued to a Subscriber (Member) upon our approval of an Application that identifies you as a Covered Member of your Group Health Benefits Plan.

Immunosuppressive Drugs means Prescription Drugs/Medications used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include, but are not limited to:

- Preventing transplant rejection
- Supplementing chemotherapy
- Treating certain diseases of the immune system (i.e., "autoimmune" diseases)
- Reducing inflammation
- Relieving certain symptoms
- Other times when it may be helpful to suppress the human immune response

Independent Quality Review Organization (IQRO) means an organization independent of the Healthcare Insurer or managed healthcare organization that performs external quality audits of Managed Healthcare Plans and submits reports of its findings to both the Healthcare Insurer and the managed healthcare organization and to the Division.

In-network Pharmacy means any duly licensed pharmacy, which has entered into an agreement with us to dispense Prescription drugs/Medications to our Members.

In-network Physician means any licensed Practitioner of the healing arts acting within the scope of his or her license who has entered into an agreement directly with us to provide Healthcare Services to our Members.

In-network Practitioner/Provider means a Practitioner/Provider who, under a contract or through other arrangements with us, has agreed to provide Healthcare Services to Covered Persons, known as Members, with an expectation of receiving payment, other than Cost-Sharing Deductibles, Coinsurance and/or Copayments), directly or indirectly from us.

Inpatient means a Member who has been admitted by a healthcare Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for which there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital. This may also be known as Hospitalization.

Long-term Therapy or Rehabilitation Services means therapies that the Member's Practitioner/Provider, in consultation with us, does not believe will likely result in Significant Improvement within a reasonable number of visits. Long-term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which Rehabilitation Services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome and Cerebral Palsy.

Malocclusion means abnormal growth of the teeth causing improper and imperfect matching.

Managed Care means a system or technique(s) generally used by third-party payors or their agents to affect access to and control payment for Healthcare Services. Managed Care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services
- Contracts with selected healthcare Practitioner/Providers
- Financial incentives or disincentives for Covered Persons to use specific Practitioners/Providers, services, prescription drugs, or service sites
- Controlled access to and coordination of services by a case manager; and
- Payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care

Managed Health Care Plan (MHCP or Plan) means a Health Benefit Plan that we offer as a Healthcare Insurer that provides for the delivery of Comprehensive Basic Healthcare Services and Medically Necessary services to individuals enrolled in the plan (known as Members) through our own contracted healthcare Practitioners/Providers. This Plan either requires a Member to use, or creates incentives, including financial incentives, for a Member to

use healthcare Practitioners/Providers that we have under contract. This Plan is considered to be a Managed Health Care Plan.

Maternity Benefits means Covered benefits for prenatal, intrapartum, perinatal or postpartum care.

Medicaid means Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

Medicare Allowable means the maximum dollar amount that an insurer will consider reimbursing for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the provider as it may be reduced by any co-insurance, deductible or amount beyond the annual maximum.

Medical Drugs (Medications obtained through the medical benefit). Medical drugs are defined as medications administered in the office or facility that require a Health Care Professional to administer. They may involve unique distribution and may be required to be obtained from our specialty pharmacy vendor. Office administered applies to all outpatient settings including, but not limited to, physician's offices, infusions suites, emergency rooms, Urgent Care facilities and outpatient surgery facilities.

Medical Director means a licensed physician in New Mexico, who oversees our Utilization Management Program and Quality Improvement Program, that monitors access to and appropriate utilization of Healthcare Services and that is responsible for the Covered medical services we provide to you as required by New Mexico law.

Medical Necessity or Medically Necessary means Healthcare Services determined by a Provider, in consultation with the Health Insurance carrier, to be appropriate or necessary, according to:

- any applicable generally accepted principles and practices of good medical care;
- practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
- any applicable clinical protocols or practice guidelines developed by the Health Insurance carrier consistent with such federal, national, and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical, behavioral health condition, illness, injury, or disease.

Medicare means Title 18 of the Social Security Amendments of 1965, "*Health Insurance for Aged and Disabled*," as then constituted or later amended.

Member means the Subscriber or Dependent eligible to receive Covered Benefits for Healthcare Services under this Plan. Also known as an Enrollee.

Mental Health or Substance Abuse Use Disorder Services means professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder. Additionally, professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act Chapter 61, Article 9A NMSA 1978.

National Network means Out-of-network Practitioner/Providers, including medical facilities, with whom we have arranged a discount for Healthcare Service(s) provided out-of- state (outside of New Mexico).

Nurse Practitioner means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a Certified Nurse Practitioner pursuant to the Nursing Practice Act.

Nutritional Support means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is Covered only when enteral tube feedings are required.

Observation Services means outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Practitioner/Providers written order. Our level of care criteria must be met in order to transition from Observation Services to an Inpatient admission. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient status. Medical criteria will also be considered. Observation for greater than **24 hours** will require **Prior Authorization** by the facility.

Obstetrician/Gynecologist means a Physician who is eligible to be or who is board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

Organ means an independent body structure that performs a specific function.

Orthopedic Appliances /Orthotic Device /Orthosis means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports or eliminates motion of a weak or diseased body part. Examples of Orthopedic Appliances are functional hand or leg brace, Milwaukee Brace, or fracture brace.

Orthotic Appliance means an external device intended to correct any defect of form or function of the human body.

Out-of-network Practitioner/Provider means a healthcare Practitioner/Provider, including medical facilities, who has not entered into an agreement with us to provide Healthcare Services to our Members.

Out-of-network Services means Healthcare Services obtained from an Out-of-network Practitioner/Provider as defined above.

Out-of-pocket Maximum means the most that a Member will pay, in total Cost Sharing, during the Contract Year. Once a Member has reached the Annual Out-of-pocket Maximum limit, we will pay 100 percent (**100%**) of the Medicare Allowable. The Annual Out-of-pocket Maximum includes Deductible, Coinsurance and Copayments Cost Sharing (including **Self-Administered Specialty Drugs**) and does not include non-covered charges including charges incurred after the benefit maximum has been reached. Covered charges for In-network Practitioner/Provider services do not apply to the Out-of-network Practitioner/Provider Annual Out-of-pocket Maximum, and Covered charges for Out-of-network Practitioner/Provider services do not apply to the In-network Practitioner/Provider Annual Out-of-pocket Maximum.

Over the counter (OTC) means a drug for which a prescription is not normally needed.

Palliative Care means specialized medical care for people with serious illnesses. It is provided by an interdisciplinary team of clinicians and other specialists, who work with the member's other providers to provide an extra layer of support.

Personal Representative means a parent, guardian, or other person with legal authority to act on behalf of an individual in making decisions related to healthcare.

Pharmacist may order, test, screen, treat and provide preventive services for health conditions or situations that include:

- 1) Influenza;
- 2) Group A streptococcus pharyngitis;
- 3) SARS-COV-2;
- 4) Uncomplicated urinary tract infection;
- 5) Human immunodeficiency virus, limited to the provision of pre-exposure prophylaxis and post-exposure prophylaxis; and
- 6) Other emerging and existing public health threats identified by the board or department of health during civil or public health emergencies.

Pharmacy Benefits Management means a service provided to or conducted by a health plan as defined in Section 59A-16-21.1 NMSA 1978 or health insurer that involves:

- 1) Prescription drug claim administration;
- 2) Pharmacy network management;
- 3) Negotiation and administration of prescription drug discounts, rebates and other benefits;
- 4) Design, administration or management of prescription drug benefits;
- 5) Formulary management;
- 6) Payment of claims to pharmacies for dispensing prescription drugs;
- 7) Negotiation or administration of contracts relating to pharmacy operations or prescription benefits; or
- 8) Any other service determined by the superintendent as specified by rule to be a pharmacy benefits management activity.

PHP Video Visit means a virtual visit with a contracted provider. These visits can be accessed through the myPRES portal.

Physician means any licensed Practitioner of the healing arts acting within the scope of his/her license.

Physician Assistant means a skilled person who is a graduate of a Physician Assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Physician Assistants, and who is licensed to practice medicine, usually under the supervision of a licensed Physician.

PIC means Presbyterian Insurance Company, Inc., a corporation organized under the laws of the state of New Mexico.

PPACA means Patient Protection and Affordable Care Act.

PPO means Preferred Provider Organization.

Practitioner/Provider means any licensed Practitioner of the healing arts acting within the scope of his/her license.

Practitioner of the Healing Arts means a Healthcare Professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

Preferred (as it refers to medication and diabetic supplies) means medication that is selected for inclusion on Preferred tiers of the *Formulary* based on clinical efficacy, safety, and financial value.

Premium means the amount paid for a Contract of health insurance.

Prepayment means the monthly amount of money we charge payable in advance for Covered Benefits provided under this Plan in accordance with the applicable Administrative Services Agreement (ASA) or non-Group Membership Letter of Agreement.

Prescription Drugs/Medications means those drugs that, by federal law, require a Practitioner's/Provider's prescription for purchase (the original packaging of which, under the federal Food, Drug and Cosmetic Act, is required to bear the legend, Caution: Federal law prohibits dispensing without a prescription or is so designated by the New Mexico State Board of Pharmacy as one which may only be dispensed pursuant to a prescription).

Primary Care Provider/Physician/Practitioner (PCP) means a Healthcare Professional who, within the scope of the professional license, supervises, coordinates, and provides initial and basic care to Covered Persons, who initiates the patient's referral for specialist care, and who maintains continuity of patient care.

PCPs include General Practitioners, Family Practice Physicians, Geriatricians, Internists, Pediatricians, and Obstetricians/Gynecologists, Physician Assistants and Nurse Practitioners. Pursuant to 13.10.21.7 NMAC, other Healthcare Professionals may also serve as Primary Care Practitioners.

Prior Authorization or Pre-Certification means a pre-service determination made by a Health Insurance carrier regarding a covered person's eligibility for healthcare services based on medical necessity, health benefits coverage and the appropriateness and site of service pursuant to the terms of the health benefits plan.

Prosthetic Device means an artificial device to replace a missing part of the body.

Provider means a licensed Healthcare Professional, hospital or other facility authorized to furnish Healthcare Services.

Pulmonary Rehabilitation means a program of therapy designed to improve lung functions.

Reasonable/Prudent Layperson means a person who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Healthcare Services. A Reasonable/Prudent Layperson is considered to have acted "reasonably" if, after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention (including healthcare procedures, treatments, or services) could reasonably be expected to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part, or

- Disfigurement to the person

Reconstructive Surgery means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery.
- Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

Registered Lay/Licensed Midwife means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Rehabilitation Facility means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

Rehabilitation Services means Healthcare Services that help a Member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a Member was sick, injured or disabled. These services may include physical and occupational therapy, and speech-language pathology in a variety of Inpatient and/or Outpatient settings.

Remitting Agent means the person or entity designated by the Group to collect and remit the Prepayment to us.

Rescission of Coverage means a cancellation or discontinuance of Coverage that has retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of Coverage has only a prospective effect, or
- The cancellation or discontinuance of Coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums, Prepayments or contributions towards the cost of Coverage.

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available **24 hours** a day.

Screening Mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic Members and includes the X-ray examination of the breast using equipment that is specifically for mammography, including the X-ray tube, filter, compression device, screens, film, and cassettes, and that has a radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast. Screening Mammography includes the professional interpretation of the film but does not include diagnostic mammography.

Self-Administered Specialty Drugs (Tier 5 Medications obtained through the Prescription Drug/Medication pharmacy benefit) Self-Administered Specialty Drugs are self-administered, meaning they are administered by the patient, a family member or caregiver. Self-Administered Specialty Drugs are often used to treat complex chronic, rare diseases and/or life-threatening conditions. Most Self-Administered Specialty Drugs require **Prior Authorization** and must be obtained through the specialty pharmacy network. Self-Administered Specialty Drugs are often high cost, typically greater than **\$600** for a **30-day** supply.

Self-Administered Specialty Drugs are not available through the mail order option and are limited to a **30-day** supply. Certain Self-Administered Specialty Drugs are limited to an initial fill up to a **14-day** supply to ensure patients can tolerate the new medication. For a complete list of these drugs, please see the Health Insurance Exchange Metal Level Plan *Formulary* list at www.phs.org. The medications listed on the *Formulary* are subject to change pursuant to the management activities of Presbyterian Insurance Company. You can call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-6980**, or **1-800-923-6980**. Hearing impaired users may call **TTY 711**.

Service Area means the geographic area in which we are authorized to provide services as a Preferred Provider Organization and includes the entire state of New Mexico.

Short-term Rehabilitation means Rehabilitation Services and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected.

Significant Improvement means that:

- The patient is likely to meet all therapy goals for a reasonable number of visits of therapy or
- The patient has met all therapy goals in the preceding visits of therapy, as specifically documented in the therapy record.

Skilled Nursing Facility means an institution that is licensed under state law to provide skilled care nursing care services.

Smoking Cessation Counseling/Program means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow up.
- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies,

clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying a Member's attendance.

- Employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities.
- Uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

Special Medical Foods means nutritional substances in any form that are used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require **Prior Authorization** through Presbyterian's Pharmacy Department.

Specialty Pharmacy – Presbyterian's In-network Pharmacy vendor that, under contract or other arrangement with us, provides Covered **Self- Administered Specialty Drugs** to Members.

Spouse - Legally married husband or wife.

Subluxation (Chiropractic) means misalignment, demonstrable by x-ray or Chiropractic examination, which produces pain and is correctable by manual manipulation.

Subscriber means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health benefits plan, or in the case of an individual Contract, the Person in whose name the Contract is issued.

Substance Use Disorder means dependence on or abuse of substances meeting the criteria as stated in the DSM-5 for these disorders.

Summary of Benefits means a summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective subscriber or covered person by the Health Insurance carrier.

Summary Plan Description (Plan) means the booklet which describes the Covered Benefits for which the Member and his/her eligible Dependents (if any) are eligible for under the terms of the employer's Group Contract.

Superintendent means The Superintendent of Insurance, the Office of the Superintendent of Insurance (OSI), or employees of OSI acting with the Superintendent's authorization.

Supplemental Breast Examination means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

- used to screen for breast cancer when there is no abnormality seen or suspected; and

- based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

Surprise bill is an unexpected bill from a health care provider or facility. This can happen when a person with health insurance unknowingly gets medical care for a provider, facility, or provider of air ambulance services outside their health plan's network. Surprise billing happens in both emergency and non-emergency care settings.

Telemedicine means the use of telecommunications and information technology to provide clinical health care from a distance. Telemedicine allows healthcare professionals to evaluate, diagnose and treat patients using telecommunications and technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver healthcare services to a site where the patient is located, along with the use of electronic media and health information. Telemedicine allows patients in remote locations to access medical expertise without travel.

Temporomandibular Joint (TMJ) is the joint that hinges the lower jaw (mandible) to the temporal bone of the skull.

Termination of Coverage means the cancellation or non-renewal of Coverage provided by a Healthcare Insurer to a Covered Person/Grievant but does not include a voluntary termination by a Covered Person/Grievant or termination of the Health Benefits Plan that does not contain a renewal provision.

Tertiary Care Facility means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Tobacco means cigarettes (including roll-your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, chuttas, and dhumti), pipe, smokeless Tobacco (including snuff, chewing Tobacco and betel nut), and novel Tobacco products, such as *eclipse*, *accord* or other low-smoke cigarettes.

Total Allowable Charges means, for In-network Practitioner/Providers, the Total Allowable Charges may not exceed the amount the Practitioner/Provider has agreed to accept from us for a Covered service. For Out-of-network Practitioner/Providers, the Total Allowable Charges may not exceed Medicare Allowable Charge as we determine for a service.

Traditional Fee-for-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Covered Persons/Grievants to utilize preferred (In-network) Practitioner/Providers, to follow pre-authorization (**Prior Authorization**) rules, to utilize Prescription Drug Formularies or other cost-saving procedures to

obtain Prescription Drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by a Healthcare Insurer consistent with the federal, national, and professional practice guidelines that are used by a Healthcare Insurer in determining whether to certify/authorize or deny a requested Healthcare Service.

Urgent Care Situation means a situation in which a Prudent Layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

- The life or health of the covered person would otherwise be jeopardized;
- The covered person's ability to regain maximum function would otherwise be jeopardized;
- In the opinion of a physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without care or treatment;
- The medical exigencies of the case require expedited care; or
- The covered person's claim otherwise involves urgent care.

Urgent Care Center means a facility operated to provide Healthcare Services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Utilization Review means a system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

Vocational Rehabilitation means services which are required in order for the individual to prepare for, enter, engage in, retain or regain employment.

Well-child Care means routine pediatric care and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

Women's Healthcare Practitioner/Provider means any Practitioner/Provider who specializes in Women's Healthcare and who we recognize as a Women's Healthcare Practitioner/Provider.

This Summary Plan Description is issued to the Group for the Subscriber named in an Application received and accepted by Presbyterian Insurance Company, Inc., a New Mexico corporation. The terms and conditions appearing herein, and any applicable amendments are part of this Summary Plan Description.

IN WITNESS THEREOF, Presbyterian Insurance Company, Inc. has caused this Summary Plan Description to be executed by a duly authorized agent.

PRESBYTERIAN INSURANCE COMPANY, INC.

A handwritten signature in black ink, appearing to read "Brandon Fryar". The signature is written in a cursive style with a large initial "B".

Brandon Fryar
President
Presbyterian Insurance Company, Inc.

Exhibit A – Statement of ERISA Rights

The Group healthcare Coverage provided by your employer may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The statement of ERISA rights is applicable to all Group plans except governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens.

If applicable, as a participant in your employer's Group healthcare plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants be entitled to:

Article I. Receive Information about your Plan and Plan Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Section 1.01 Continue Group Health Plan Coverage

- Continue healthcare Coverage for yourself, Spouse or Dependents if there is a loss of Coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such Coverage.
- Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Article II. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your

plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining healthcare benefits or exercising your rights under ERISA.

Section 2.01 Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within **30 days**, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to **\$110** a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Section 2.02 Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, or at the Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210, or the U.S. Department of Health and Human Services at **1-877-696-6775** or www.cciio.cms.gov. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272**.

Notice of Nondiscrimination and Accessibility *Discrimination is Against the Law*

Presbyterian Healthcare Services is committed to equitable healthcare and exists to improve the health of patients, members and the communities we serve. We value diversity and inclusion and strive to treat all individuals with respect. We do not discriminate on the basis of race; color; ancestry; national origin (including limited English proficiency); citizenship; religion; sex (including pregnancy, childbirth or related medical conditions); marital status; sexual orientation; gender identity or expression; veteran status; military status; family care or medical leave status; age; physical or mental disability; medical condition; genetic information; ability to pay; or any other protected status. Presbyterian will provide reasonable accommodations and language access services for our patients, members, and workforce.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with use, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-5420, 1-855-592-7737, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated against you in another way, you can file a grievance with Presbyterian by calling 1-866-977-3021, TTY 711, fax (505) 923-5124, or <https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer>.

You can also file a complaint with these state agencies:

Address: Office of Superintendent of Insurance
Managed Health Care Bureau
P.O. Box 1689
Santa Fe, NM 87501-1689

Phone: (505) 827-4601 or toll-free 1-855-427-5674

Online:* mhcb.grievance@osi.nm.gov

Address: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501

Phone: (505) 490-4060 or toll-free 1-844-255-9210

Fax: (505) 490-4883

*To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit <https://www.nmag.gov/consumer-complaint-instructions.aspx>.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

Address: U.S. Department of Health and Human Services200
Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Aviso de no discriminación y accesibilidad *La ley prohíbe la discriminación*

Presbyterian Healthcare Services se compromete a prestar servicios de atención médica equitativos y existe con el fin de mejorar la salud de los pacientes, de los asegurados y de las comunidades que servimos. Valoramos la diversidad y la inclusión y nos esforzamos por tratar a todos con respeto. No discriminamos por motivos de raza; color; linaje; origen nacional (incluso por dominio limitado del inglés); ciudadanía; religión; sexo (incluso por embarazos, partos o problemas médicos conexos); estado civil; orientación sexual; expresión o identidad de género; estado de veterano; estado militar; estado de ausencia familiar o médica; edad; discapacidad física o mental; estado médico; datos genéticos; capacidad de pago; o cualquier otro estado protegido. Presbyterian proporcionará adaptaciones razonables y servicios de acceso al idioma a nuestros pacientes, asegurados y fuerza laboral.

Presbyterian Healthcare Services:

- Presta servicios y ayuda a las personas con discapacidades para que se puedan comunicar efectivamente, por ejemplo:
 - Intérpretes calificados de lengua de señas
 - Información escrita en otros formatos (letra grande, grabaciones de audio, formatos electrónicos accesibles y otros formatos)
- Proporciona servicios gratuitos de acceso al idioma a las personas cuyo idioma principal no es inglés, por ejemplo:
 - Intérpretes calificados
 - Información escrita en otros idiomas

Si necesita alguno de esos servicios, llame al Centro de Servicio al Cliente de Presbyterian al (505) 923-5420, 1-855-592-7737, TTY 711.

Si cree que Presbyterian Healthcare Services no le ha proporcionado dichos servicios o si cree que le han discriminado de alguna otra manera, puede presentar una reclamación a Presbyterian si llama al 1-866-977-3021, TTY 711, fax (505) 923-5124, o <https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer>.

Además puede presentar una queja formal referente a los derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. electrónicamente en el portal de quejas de la Oficina de Derechos Civiles, que está a su disposición en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o por teléfono al:

Además puede presentar queja a las agencias estatales siguientes:

Dirección: Office of Superintendent of Insurance
Oficina del Superintendente de Seguros
Managed Health Care Bureau
Oficina de Atención Médica Administrada

P.O. Box 1689
Santa Fe, NM 87501-1689

Teléfono: (505) 827-4601 o gratis al 1-855-427-5674

En línea:* mhcb.grievance@osi.nm.gov

Dirección: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501

Teléfono: (505) 490-4060 o gratis al 1-844-255-9210

Fax: (505) 490-4883

*Para llenar el Formulario de Queja del Consumidor o para bajar el formulario a su computadora, ya sea en inglés o español, visite <https://www.nmag.gov/consumer-complaint-instructions.aspx>.

Dirección: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Número de teléfono (gratuito): 1-800-368-1019, 800-537-7697 (TDD)

Los formularios de quejas están a su disposición en <http://www.hhs.gov/>.

Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáńítł'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jüük'eh, éí ná hóló, kóji' hódíilnih 505-923-5420, 1-855-592-7737 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 505-923-5420, 1-855-592-7737 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: 505-923-5420, 1-855-592-7737 (TTY: 711) رقم هاتف الصم والبكم.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오.
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420、1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).