BENEFITS

University of New Mexico Medical Plan Participant Benefit Booklet

Effective July 1, 2024 - June 30, 2025

Offered by the Regents of the University of New Mexico for its Public Operation Known as UNM

Administered by Presbyterian Health Plan, Inc.

MPC052492

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WELCOME

The Regents of the University of New Mexico, for its public operation known as UNM ("UNM") offers healthcare benefits through the UNM Medical Plan ("Plan").

UNM is committed to maintaining affordable, quality healthcare for employees. The UNM Medical Plan is self-insured, meaning UNM is responsible for paying medical and prescription drug claims incurred by Participants. Over 90% of the premiums paid by UNM and employees pay for claims costs. Administrative costs account for less than 10% of the premiums paid by UNM and employees. Administrative costs include expenses for contracting with Third Party Administrators and UNM's Pharmacy Benefits Manager for claims processing, provider network contracting, customer service, and other services.

UNM contracts with Presbyterian Health Plan (PHP) as your Third-Party Administrator (TPA) for the administration of your medical benefits. Your TPA acts on behalf of the Plan in administering your medical benefits based on the Plan provisions outlined in your Participant Benefit Booklet (PBB). Your PBB describes the benefits and limitations of the Plan. It explains how to file claims (if applicable), how to request review of a claim, or file a claim appeal or grievance. As healthcare costs continue to increase nationally and regulatory oversight grows through Healthcare Reform, healthcare plans are becoming more complex. It is vital for UNM Medical Plan Participants to read the PBB carefully in its entirety to ensure that they maximize their UNM Medical Plan benefits.

UNM contracts with CVS Caremark as its Pharmacy Benefits Manager (PBM). Please refer to your CVS Caremark Benefit Booklet for detail information about your prescription drug benefits. The CVS Caremark Benefit Booklet is available on the UNM Division of Human Resources website at: **https://hr.unm.edu/benefits/prescriptions**.

Please take the time to read the PBB carefully and keep it in a safe place for future reference. Your PBB is also available online at **https://hr.unm.edu** or at **www.phs.org**. If you have questions, please refer to the Contact Information section on page four. It is best to call for clarification before services are rendered to ensure proper Plan procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

CONTACT INFORMATION

When you have questions about your Plan, knowing your resources is the best way to proactively ensure efficient use of your Plan and resolve issues quickly. For questions about benefits provided under the Plan, your first point of contact is your TPA or PBM Customer Service Center. Your TPA or PBM Customer Service Representative will assist you with questions about coverage, provider networks, claims, prior authorization, billing, appeals and grievances, and any other questions you might have about your Plan benefits.

The Division of Human Resource's Benefits & Employee Wellness department (Benefits & Employee Wellness) is responsible for administering eligibility. If you have a question about eligibility, including enrollment as a new hire or if you experience a qualified change of status event such as marriage, birth or adoption of a child, or divorce, you should contact Benefits & Employee Wellness **before** the event to ensure you follow the correct enrollment policies and procedures.

QUESTIONS ABOUT:	CONTACT:
Eligibility Questions about initial enrollment, adding dependents, qualifying change of status events, proof documentation, eligibility rules	**UNM Division of Human Resources** **Benefits & Employee Wellness** **Phone: (505) 277-MyHR** or **((505) 277-6947)** **Website: https://hr.unm.edu/benefits**
Medical Plan TPA Questions about plan coverage, prior authorization, provider networks, billing, Explanations of Benefits, medical appeals and grievance procedures	**Presbyterian Health Plan** **Customer Service: (505) 923-5232** or **1-866-574-9567** **Website: www.phs.org**
Prescription Drug PBM	**CVS Caremark** **Customer Service: 1-877-745-4394** **Website: https://www.caremark.com/**
LoboCare Network Questions about accessing services in the LoboCare Network	**Scheduling: (505) 272-8481** **Website: http://hsc.unm.edu/lobocare/**
COBRA Administrator Questions about continuation of coverage after you and/or a dependent are no longer eligible for coverage	**Chard Snyder** **Customer Service: 1-888-993-4646** **Website: www.chard-snyder.com**

SCHEDULE OF BENEFITS

UNM Medical Plan Benefits and Coverage	LoboCare	In-Network [6]	Out-of-Network[1]
Annual Plan Year Deductible (Deductible must be met for services subject to the deductible before benefits are paid)	Individual: $600[3] Family: $1,200[3]		Individual: $1,800 Family: $3,600
Annual Plan Year Out-Of-Pocket Maximum	Individual: $3,000 Family: $6,000 (Includes: Medical Deductible, Medical and Prescription Coinsurance and Copayments)		Individual: $7,500 Family: $15,000 (Includes Medical Coinsurance **Only**. **Excludes** Medical Deductible and Prescription Copayments and Coinsurance)
Annual and Maximum Lifetime Benefit	Unlimited		
Pre-Existing Condition Exclusion	None		
Provider/Practitioner Services This includes the following: • Non-specialist office visits – (non-preventive)	$25[2,3] Copay per visit	$30[2,3] Copay per visit	40%[5] Coinsurance
• Specialist office visits – (non-preventive)	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance
• Virtual Visits/Telehealth Visits (PCP/Specialist)	$25/$35[2,3] Copay per visit	$30/$45[2,3] Copay per visit	Not Covered
• Outpatient surgery (in-Provider/Practitioner's office)	Included in office Copay	Included in office Copay	40%[5] Coinsurance
Allergy services • Testing and Extract • Injections Only (no office visit billed)	$55[2,3] Copay No Copay[2]	$55[2,3] Copay No Copay[2]	40%[5] Coinsurance 40%[5] Coinsurance
• Injections such as insulin, heparin and antibiotics	Included in office visit Copay	Included in office visit Copay	40%[5] Coinsurance
• Infertility services – diagnosing only Non-specialist office visits	$25[2,3] Copay per visit	$30[2,3] Copay per visit	40%[5] Coinsurance
• Specialist office visit	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance

SCHEDULE OF BENEFITS

UNM Medical Plan Benefits and Coverage	LoboCare	In-Network [6]	Out-of-Network[1]
Hospital Services – Inpatient[1][7] Coverage includes the following: • Room and board • Newborn delivery and other • Hospital obstetrical services • In-hospital Provider/Practitioner visits, Surgeons, Anesthesiologist and other Inpatient services • Detoxification • Administration of blood/blood components	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Medical Services – Outpatient			
Surgeries[1][7] • Hospital/ASC Facility Fees • Professional Fees	15%[3,4] Coinsurance 15%[3,4] Coinsurance	25%[3,4] Coinsurance 25%[3,4] Coinsurance	40%[5] Coinsurance 40%[5] Coinsurance
X-ray, laboratory, and diagnostic tests (Not including CT/ PET Scans, MRI, or Nuclear Medicine) • Preventive • Non-preventive	No Copay[2] No Copay[2]	No Copay[2] No Copay[2]	40%[5] Coinsurance 40%[5] Coinsurance
Endoscopy Colonoscopy (Non-preventive)	15%[3,4] Coinsurance No Copay[2]	25%[3,4] Coinsurance No Copay[2]	40%[5] Coinsurance 40%[5] Coinsurance
Radiation therapy (non-surgical) [1] • In Provider/Practitioner's office • Outpatient facility	Office visit Copay[2,3] 15%[3,4] Coinsurance	Office visit Copay[2,3] 25%[3,4] Coinsurance	40%[5] Coinsurance 40%[5] Coinsurance
Chemotherapy[1] • In Provider/Practitioner's office • Outpatient facility	Office Visit Copay[2,3] 15%[3,4] Coinsurance	Office visit Copay[2,3] 25%[3,4] Coinsurance	40%[5] Coinsurance 40%[5] Coinsurance
Computed Axial Tomography (CAT) Scans[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Positron Emission Tomography (PET) Scans[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Magnetic Resonance Imaging (MRI) tests[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Sleep studies	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Nuclear Medicine[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance

SCHEDULE OF BENEFITS

UNM Medical Plan Benefits and Coverage	LoboCare	In-Network[6]	Out-of-Network[1]
Reconstructive Surgery[1]	Usual copayment or coinsurance based on place of treatment and type of service[2,3,4,5,7,9]		
Emergency Room Care **Including trauma services**	$150[2,3] Copay per visit	$150[2,3] Copay per visit	$150[2,3] Copay per visit
Urgent Care Virtual Visits/Telehealth Visits (Urgent Care)	$75[2,3] Copay per visit	$75[2,3] Copay per visit	40%[5] Coinsurance
Video Visits (Virtual National Carrier 24/7)	Not Available	$10 Copay	Not Covered
Ambulance Services This includes the following: • Emergency or high-risk Ground and Air ambulance. • Inter-facility transfer services Ground and Air ambulance.	25% Coinsurance No Copay[2]	25% Coinsurance No Copay[2]	25% Coinsurance No Copay[2]
Clinical Preventive Services This includes the following: • Well-child care including vision and hearing screening. • Preventive physical exam. • Adult and child immunizations. • Office based health education. • Family Planning Services. • Colonoscopy.	No Copay[2,8]	No Copay[2,8]	40%[5] Coinsurance (No Copay if using a National Network Provider)
Women's Healthcare The following Preventive Care Services: • Well-woman visits to include adult and female-specific screenings. • Mammograms. • Cytologic Screening (Pap tests) including screening for papillomavirus. • Screening for gestational diabetes. • Counseling for HIV and sexually transmitted infections. Screening and counseling for interpersonal and domestic violence.	No Copay[2,8]	No Copay[2,8]	40%[5] Coinsurance (No Copay if using a National Network Provider)

SCHEDULE OF BENEFITS

UNM Medical Plan Benefits and Coverage	LoboCare	In-Network[6]	Out-of-Network[1]
Women's Healthcare (continued) Preventive Care Services: • Food and Drug Administration (FDA) Approved Surgical sterilization procedures for women's sterilization • Contraceptive implant insertion/re-insertion fee • Contraception counseling • Breast feeding support, supplies and counseling[8]	No Copay[2,8]	No Copay[2,8]	40%[5] Coinsurance (No Copay if using a National Network Provider)
Non-preventive Non-specialist	$25[2,3] Copay per visit	$30[2,3] Copay per visit	40%[5] Coinsurance
Specialist (includes Perinatologist)	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance
Obstetrical/Maternity/Prenatal and Postnatal care (excludes delivery)	$25[2,3] Copay for first visit. (Plan pays 100% thereafter)	$30[2,3] Copay for first visit. (Plan pays 100% thereafter)	40%[5] Coinsurance
Diabetes Services Office visit and Diabetes Education Non-specialist	$25[2,3] Copay per visit	$30[2,3] Copay per visit	40%[5] Coinsurance
Specialist	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance
Certified Diabetes Educator and Training Telephone visits	No Copay[2]	No Copay[2]	Not Covered
Diabetic supplies [1] (If purchased through a Durable Medical Equipment Provider). Other Diabetic Supplies are covered under the CVS Caremark Prescription Drug Benefit.	Not Available	25%[3,4] Coinsurance	40%[5] Coinsurance
Prescription Drugs[2,3]	**Administered by CVS Caremark**. Call CVS Caremark at **1-877-745-4394**.		

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UNM Medical Plan Benefits and Coverage	LoboCare	In-Network[6]	Out-of-Network[1]
Mental Health Services Outpatient[1]	$10[2,3] Copay per visit	$10[2,3] Copay per visit	40%[5] Coinsurance
Inpatient/Partial Hospitalization[1] Residential Treatment Center (RTC)[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
(Up to 60 days per Annual Plan Year)	**Not available**	25%[3,4] Coinsurance	40%[5] Coinsurance
Alcohol and Substance Use Services Rehabilitation Outpatient[1]	$10[2,3] Copay per visit	$10[2,3] Copay per visit	40%[5] Coinsurance
Inpatient/Partial Hospitalization[1]	Not Available	25%[3,4] Coinsurance	40%[5] Coinsurance
Detoxification Outpatient[1]	$10[2,3] Copay per visit	$10[2,3] Copay per visit	40%[5] Coinsurance
Inpatient/Partial Hospitalization[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Residential Treatment Center (RTC)[1] (Up to 60 days per Annual Plan Year)	Not Available	25%[3,4] Coinsurance	40%[5] Coinsurance
Rehabilitation and Therapy Services Cardiac rehabilitation (36 visits per Annual Plan Year) [1]	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance
Dialysis/Plasmapheresis/Photopheresis	15%[3,4] Coinsurance	20%[3,4] Coinsurance	40%[5] Coinsurance
Pulmonary Rehabilitation [1] (up to 24 visits per Annual Plan Year)	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance
Short-term rehabilitation (up to 70 visits combined per Annual Plan Year, if determined medically necessary, additional visits may be approved.) • Physical therapy • Occupational therapy • Speech and Hearing Therapy	$25[2,3] Copay per visit	$30[2,3] Copay per visit	40%[5] Coinsurance

SCHEDULE OF BENEFITS

UNM Medical Plan Benefits and Coverage	LoboCare	In-Network[6]	Out-of-Network[1]
Autism/Applied Behavioral Analysis[1]	Usual copayment or coinsurance based on place of treatment and type of service.[2,3,4,5,7,9]		
Transplants[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	Not Covered
Complementary Therapies (Limited to a combined total of 40 visits per Annual Plan Year			
• Acupuncture treatment	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance
• Chiropractic services	$35[2,3] Copay per visit	$45[2,3] Copay per visit	40%[5] Coinsurance
Skilled Nursing Facility[1] (Up to 60 days per Annual Plan Year)	Not Available	25%[3,4] Coinsurance	40%[5] Coinsurance
Home Healthcare Services/ Home Intravenous Service[1] Services provided by a registered nurse and other specified specialist to include, but not limited to, home IV services (up to 100 days per Annual Plan Year)	Not Available	25%[3,4] Coinsurance	40%[5] Coinsurance
Hospice Care[1] LoboCare services limited to Pediatric Hospice only.	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Durable Medical Equipment, Prosthetics, Orthotics and Appliances[1]	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Hearing Aids Up to $2,500 every 36 months “per hearing-impaired ear.”	Applies to In-Network Level of Benefits	25%[3,4] Coinsurance	40%[5] Coinsurance

SCHEDULE OF BENEFITS

UNM Medical Plan Benefits and Coverage	LoboCare	In-Network[6]	Out-of-Network[1]
Eyeglasses and Contact Lenses Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus.[1] • Refraction eye exam associated with post-cataract surgery or Keratoconus correction.	15%[3,4] Coinsurance 15%[3,4] Coinsurance	25%[3,4] Coinsurance 25%[3,4] Coinsurance	40%[5] Coinsurance 40%[5] Coinsurance
Dental Services (Limited)/ CMJ/Temporomandibular Joint Dysfunction	15%[3,4] Coinsurance	25%[3,4] Coinsurance	40%[5] Coinsurance
Family, Infant and Toddler Program (FIT) Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Healthcare Services.	No Copay[2] $3,500 per Participant per Plan Year Maximum annual benefit. Not applicable to any lifetime maximums or annual limits.	No Copay[2]	Not Covered

Footnotes:

[1] Benefit Certification/Prior Authorization may be required.

[2] Not Subject to the Deductible.

[3] Included in the LoboCare/In-Network Out-of-Pocket Maximum.

[4] Subject to the In-Network Deductible.

[5] Subject to Out-of-Network Deductible and applies to the Out-of-Network Out-of-Pocket Maximum.

[6] National Network Providers/Practitioners outside of New Mexico are considered to be In-Network for claims payment purposes. Prior to receiving services from National Network Providers, please work with the National Network Provider in obtaining Benefit Certification//Prior Authorization.

[7] Each Inpatient or Outpatient facility visit will generate at least two claims; a facility claim and a professional claim, both will apply Deductible and Coinsurance.

[8] The Patient Protection and Affordable Care Act requires the UNM Medical Plan to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to Participants when the services are provided by a LoboCare or In-Network Participating Provider. Though these specific services are covered at no charge, the provider may charge a copayment or other applicable fees for other services provided during the office visit. Additionally, some covered Family Planning services, for example male vasectomies, continue to require some Participant cost-sharing. If you have questions regarding the Preventive Care Services that are covered under your plan, including Family Planning services, or your cost for these services, please refer to your PBB or contact the Customer Care Center.

[9] Patients are responsible for Copayments related to place of service, ancillary services, and additional procedures performed at the same time. Benefit Certification/Prior Authorization rules still apply.

ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES

Eligibility, Enrollment, and Effective Dates

UNM will determine who is eligible to enroll based on current UNM policies, procedures, and employment practices. To be eligible for Covered Services you must be enrolled as a Participant. To be eligible as a Participant, you must meet either the Employee or Dependent eligibility criteria listed below.

You must enroll within **60 calendar days** from your date of eligibility, or during Open Enrollment. Late enrollments are not accepted. Mid-year enrollments are only allowed when you experience a permitted Qualifying Change in Status.

Initial Enrollment

- The default effective date of Coverage is the first of the month following the date of enrollment. For initial enrollment only, you may choose to make coverage effective the date of enrollment, in which case premiums are not prorated for the month and you will pay the employee portion of the premium for the entire month irrespective of the effective date of coverage.
- You are not eligible for benefits before your date of hire or date of eligibility.

Late Enrollments Not Accepted
If you fail to enroll yourself/dependents within the initial eligibility period, you will not be able to enroll unless you experience a qualifying status change, or until Open Enrollment, which is in the spring. Enrollment during Open Enrollment will not become effective until July 1 of that year.

EMPLOYEE ELIGIBILITY CRITERIA **YOU BECOME ELIGIBLE ON THE FIRST DAY YOU ARE EMPLOYED IN A BENEFITS ELIGIBLE POSITION**	
Staff	• Regular full-time or part-time employees. • Appointment percent of 50% or greater.
Temporary Staff	• At least three-month appointment. • Appointment of 75% or greater.
Faculty	• At least three-month contract. • Full-time or part-time employees. • Appointment percent of 50% or greater.

ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES

EMPLOYEE ELIGIBILITY CRITERIA YOU BECOME ELIGIBLE ON THE FIRST DAY YOU ARE EMPLOYED IN A BENEFITS ELIGIBLE POSITION	
Adjunct Faculty	• At least three-month contract. • Appointment of 75% or greater.
Term Employee	• Minimum term of three months. • Appointment percent of 50% or greater.
Post-Doctoral Fellow	• At least three-month contract. • Regular full-time or part-time employees. • Appointment percent of 50% or greater.
UNM Affiliates	Employees of the UNM Affiliate Employers UNM Hospitals, UNM Medical Group, and STC.UNM.
Joint Appointment Employees	Employees, as determined by UNM, who are employed through a joint appointment with any Federal or State agency.
Early Retirees	UNM approved Retirees and dependents who are under age 65 or not eligible for Medicare.

Dependent Enrollment

- Dependent enrollment to your coverage provided you submit the necessary proof documentation.
- Initial dependent enrollment must be within 60 days of your eligibility date (ideally at the same time as you enroll). Otherwise, you may be able to add dependents outside of an enrollment period when you experience a Qualified Family Status Change or Special Enrollment event.
    - Documentation supporting dependent eligibility, such as a valid marriage certificate, birth certificate, or Affidavit of Domestic Partnership, must be provided to UNM's contracted dependent verification vendor when requested.

Eligible Dependents Include:

- A legal spouse, surviving spouse, or domestic partner.
- Dependent children to age twenty-six (26)

  - Dependent children include natural children, stepchildren, legally adopted children, children placed for adoption, and children who are under the legal guardianship of the employee.
- Mentally or physically disabled dependent children over age twenty-six (26) if disabled prior to turning twenty-six (26), have maintained health coverage since turning age twenty-six (26), and providing documentation certifying disability (periodic recertification of disability may be required).

NOTE: Benefits & Employee Wellness may request documents supporting dependent eligibility at any time. Documents supporting dependent eligibility must be provided when requested. Failure to provide proof of dependent eligibility may result in the cancellation of dependent coverage, and UNM may seek reimbursement of associated paid claim costs.

Surviving Spouse Coverage

- Surviving spouses of employees who were active at the time of death are eligible to continue coverage for 12 months after employee's death as long as the applicable premium is paid. UNM will continue premium contributions based on the employee's salary prior to death. After the 12-month period, coverage may be continued through COBRA provisions.
- Surviving dependent children can only continue coverage for the 12-month period after the death of an active employee if he or she is covered as a dependent of a surviving spouse, as long as he or she continues to meet dependent eligibility criteria. Dependent children may continue through COBRA provisions at the end of the 12-month period, or when he or she loses dependent eligibility, whichever is earlier.
- Surviving spouses of under age 65 retirees are eligible to continue coverage until he or she is eligible for Medicare, as long as the applicable premium is paid. UNM will continue premium contributions for surviving spouses for 12 months following the death of a retiree at the same contribution rate prior to the retiree's death. After 12 months, the surviving spouse may remain covered by the Plan by paying 100% of the total premium until he or she reaches Medicare eligibility. At the time of Medicare eligibility, surviving spouses of retirees may elect a UNM Medicare plan.
- Surviving dependent children of an under age 65 retiree may continue coverage only if he or she is covered as the dependent of a surviving spouse of an under age 65 retiree, as long as the he or she continues to meet dependent eligibility criteria. UNM will contribute to the premium for eligible surviving dependent children for 12 months or until he or she no longer meets eligibility criteria. After 12 months, if the dependent child still meets eligibility criteria, he or she may remain covered by the plan until he or she is no longer eligible provided the surviving spouse pays 100% of the premium for the dependent child. After the dependent child is no longer eligible, he or she may continue under COBRA provisions.

ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES

Family Status or Employment Status Changes

To enroll in coverage and/or add dependents after initial enrollment or outside of an Open Enrollment period, you or your dependents must meet the criteria for "Family Status or Employment Status Changes" or "Special Enrollment". If criteria are not met, dependents are not eligible for enrollment until Open Enrollment in the spring.

Special Enrollment

If you chose not to enroll in the Plan during a previous enrollment period but are otherwise eligible for Coverage, you may enroll in the Plan due to a Special Enrollment Event. Enrollment must be completed within **60 calendar days** of acquiring a new Dependent through marriage, birth, adoption or placement for adoption. Special Enrollment applies to the Participant, spouse, and other eligible Dependents, which include the new Dependents acquired because of the marriage, or newborn/adopted children who triggered the event.

Effective Date of Enrollment	
Marriage	Beginning of the Month Following Enrollment
Birth of a Child	Date of Birth
Adoption or Placement for Adoption	Date of Adoption or Placement for Adoption

CHIPRA (in accordance with provisions as currently may be defined under federal law)

- If you chose not to enroll in the Plan for self and/or dependent(s) during a previous enrollment period because you and/or your dependents were covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, you may enroll in coverage for self and/or any affected eligible Dependent(s) if the Dependent is eligible provided you enroll within **60 calendar days** from the date Medicaid or CHIP coverage terminated.
- If you chose not to enroll in the Plan for self and/or dependent(s) coverage during a previous enrollment period and have become eligible for group health premium assistance under State Medicaid or State CHIP, you may enroll in coverage for self and/or eligible Dependent(s) provided you enroll within **60 calendar days** of becoming eligible.
- If you apply within 60 days of the date Medicaid or CHIP coverage is terminated or within 60 days of the date the employee is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start

no later than the first day of the month following receipt of your enrollment request.

Qualified Change In Family/Employment Status

Notwithstanding the provisions specified in "Special Enrollment" of this Section, you may make certain changes to your benefit elections **within 60 calendar days** of a Qualified Change in Family or Employment status. Evidence of the change in status must be provided with your enrollment in order to change your benefit elections. Any change in coverage will become effective on the first day of the month following enrollment. The only exceptions are birth and adoption, where the additional coverage is effective retroactively to date of birth or adoption as long as enrollment is received **within 60 calendar days** from the event. Termination of a Dependent is not a qualifying event for you to change benefit plans.

Documents supporting dependent eligibility must be provided when requested by UNM's dependent verification vendor. In addition, UNM will require documentation supporting the Qualifying Change in Status Event. Failure to provide documents supporting dependent eligibility or the Qualifying Change in Status Event when requested may result in the cancellation of dependent coverage, and UNM may seek reimbursement of associated paid claim costs.

Change of Status Event Required Support Documentation

NOTE: Documentation supporting the Qualifying Change in Status Event must be submitted to Benefits & Employee Wellness. The list below is not all-inclusive.

In addition, documentation supporting dependent eligibility must be provided to UNM's dependent eligibility verification vendor when requested.

You or Your Spouse's Unpaid Leave of Absence

- Documentation supporting the effective date of the unpaid leave of absence. The change must be consistent with the event.

Marriage

- Marriage Certificate.
- Birth Certificate (If adding any child of the newly acquired spouse).

Divorce or Legal Separation

- Divorce-Final Divorce Decree.
- Legal Separation-Court Filed Legal Separation Documentation.

ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES

Change of Status Event Required Support Documentation

NOTE: Documentation supporting the Qualifying Change in Status Event must be submitted to Benefits & Employee Wellness. The list below is not all-inclusive.

In addition, documentation supporting dependent eligibility must be provided to UNM's dependent eligibility verification vendor when requested.

Birth of a Child

- Birth Certificate of Biological Child.
- If a Birth Certificate is not available for newborn children, proof of birth from the provider/hospital listing both parents and date of birth is acceptable.
- Coverage for the child will be effective retroactively to the date of birth, provided you enroll the newborn within **60 Calendar Days** from the date of birth.

Adoption or Placement for Adoption

- Official court/agency placement documentation for a child placed with you for adoption**, or**
- Official Court Adoption Agreement for an adopted child, or Birth Certificate

Coverage for the child will be effective retroactively to the date of adoption or placement for adoption, provided you enroll the child within **60 Calendar Days** from the date of adoption or placement for adoption.

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. Placement terminates or is disrupted when the legal obligation terminates.

Death of a Spouse or Dependent Child

- Death Certificate.

Change in Spouse's Employment Resulting in the Gain or Loss of other Healthcare Coverage

- Documentation supporting the gain or loss of other coverage. The documentation must provide the effective date of new coverage and the type of coverage (medical, dental, etc.).

Gain or Loss of Other Healthcare Coverage

ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES

Change of Status Event Required Support Documentation

NOTE: Documentation supporting the Qualifying Change in Status Event must be submitted to Benefits & Employee Wellness. The list below is not all-inclusive.

In addition, documentation supporting dependent eligibility must be provided to UNM's dependent eligibility verification vendor when requested.

- Documentation supporting the gain or loss of other coverage. The documentation must provide the effective date of new coverage and the type of coverage (medical, dental, etc.).

Change in Legal Responsibility for a Dependent Child

- Official court documentation requiring you to provide coverage for an eligible dependent child or releasing you from legal responsibility for the dependent child.

Dependent Child Attains Age 26

- Coverage will terminate at the end of the month the child turns 26.

Continuation of Disabled Child Over Age 26

- UNM Child Disability Affidavit signed by the employee and the child's provider.
- A disabled dependent above age 26 must have been enrolled in continuous health coverage since attaining age 26 with no more than a ninety (90) day lapse in coverage. Proof of continuous coverage must be provided in order for enrollment to be accepted.
- Proof of continuous coverage after attaining age 26.

Note: For eligibility purposes, a disabled dependent child is a child age 26 or older who prior to reaching age 26 is medically certified as disabled, chiefly dependent upon the employee for support and maintenance, and incapable of self-sustaining employment by reason of their disability. Such condition must be certified by a provider and periodic re-certification of disability may be required.

ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES

Rescission of Coverage In The Event of Fraud or Intentional Misrepresentations of Material Fact

If you knowingly make a false statement on your enrollment application or file a false claim, such application or claim may be rescinded retroactively to the date of the application or claim. Any premiums collected from you for coverage that is later revoked due to a fraudulent application may be refunded to you by the Plan. If a claim is paid by the Plan and it is later determined that the claim should not have been paid due to a fraudulent application or claim, you may be responsible for full reimbursement of the claim amount to the Plan.

Termination

Coverage under this Plan shall be canceled and shall terminate in the event any one of the following conditions occurs:

- The premiums have not been paid.
- End of the month in which eligibility ceases.
- When this Plan ends.
- Required proof documents are not provided to UNM prior to enrollment deadline.

UNM shall be entitled to recover from the Participant any and all payments made on behalf of any Participant or the Participant's Dependent(s) after the last date of the period for which payment was received.

No benefits shall be provided under this Plan subsequent to the date of termination of this Plan including, but not limited to, when the Participant remains in the Hospital subsequent to the date of termination of this Plan.

Continuation of Coverage

Participants who lose coverage because of a loss of eligibility may contact the UNM Division of Human Resources for more information about continuation through COBRA provisions.

HOW THE PLAN WORKS

You should know several basic facts as you read this booklet:

- Providers include Providers/Practitioners, Hospitals, Pharmacists, Pharmacies and other Healthcare Professionals or facilities that provide Healthcare Services.
- LoboCare Network and In-Network Provider/Practitioners, including Pharmacists and Pharmacies, have contractual agreements with your TPA and allow lower Out-of-Pocket expenses and additional benefits for covered persons.
- Out-of-Network Provider/Practitioners do not have contractual agreements with your TPA, which may increase the Out-of-Pocket expenses and limit benefits for covered persons.

General Information

Medical Necessity

This Plan helps pay for healthcare expenses that are Medically Necessary and specifically listed in the *Covered Services* section of this PBB.

- Medical Necessity or Medically Necessary means appropriate or necessary services as determined by a Provider/Practitioner, in consultation with your TPA. These necessary services are provided to a Participant for any covered condition requiring, according to generally accepted principles of good medical practice guidelines developed by the federal government, national or professional medical societies, boards, and associations, or any applicable clinical protocols. These services are also according to guidelines developed by your TPA consistent with such federal, national and professional practice guidelines for the diagnosis or direct care and treatment of an illness, injury, or medical condition. These necessary services are **not** services provided only as a convenience.

  The fact that a Provider/Practitioner has prescribed, ordered, recommended or approved a healthcare service or supply does not make it Medically Necessary even if it is not specifically listed as an exclusion.
- Covered Services means only those healthcare expenses that are expressly listed and described by this PBB.
- Your TPA, acting on UNM's behalf, determines whether a healthcare service or supply is a Covered Service. The fact that a Provider/Practitioner has prescribed, ordered, recommended, or approved a healthcare service or supply does not guarantee that it is a specifically Covered Service even if it is not listed as an exclusion.

Covered Services are subject to the following:

- The **Limitations, Exclusions,** and other provisions of this PBB.
- **Payment by the Participant** of the Copay, Deductible or Coinsurance amount, if any, directly to the Provider/Practitioner of healthcare services at the time services are rendered.

HOW THE PLAN WORKS

Provider Networks

Your Plan is a Three-Network Preferred Provider Organization or "PPO" that allows you to choose, at the time you receive Covered Services, the level of benefit that will apply, based on the network utilized when receiving Covered Services. Refer to your TPA's Provider Directory for a list of LoboCare and In-Network providers. The LoboCare Directory is available through the UNM Website at **http://hsc.unm.edu/lobocare/**. You can also contact your TPA's Customer Service Center.

As a Participant of the UNM Medical Plan, you must carefully follow all procedures and conditions for obtaining care as described throughout this PBB. Certain procedures described in this PBB require Benefit Certification/Prior Authorization. In-Network Providers (LoboCare and your TPA's network) must obtain this Prior Authorization before providing these services to you. **You are responsible** for ensuring that National Network providers outside of New Mexico and Out-of-Network Providers have obtained this Benefit Certification/Prior Authorization when Benefit Certification/Prior Authorization is required. Refer to "Benefit Certification/Prior Authorization in this Section. If you need help in obtaining Benefit Certification/Prior Authorization, please contact your TPA's Customer Service Center. You also must receive a provider referral for non-emergency related inpatient hospitalization services outside New Mexico if you reside in New Mexico.

Three-Network PPO – Three Networks of Choice/Benefits
LoboCare Network • UNM Health System providers and facilities including UNM Hospitals and associated clinics, Optum Health, Sandoval Regional Medical Center, UNM Medical Group clinics, and First Choice Community Health clinics and facilities. You pay lower copays and coinsurance amounts when you access the LoboCare Network.
In-Network • In-Network providers include Presbyterian Health Plan providers, facilities, and pharmacies within New Mexico.
Providers Outside New Mexico • Services provided by National Network Providers/Practitioners will be administered at the "In-Network" benefit level and subject to Deductibles, Coinsurance, and Copays listed in the *Schedule of Benefits* provided the following conditions are met:

HOW THE PLAN WORKS

Three-Network PPO – Three Networks of Choice/Benefits

- **Contact your TPA's Customer Service Center to determine if Benefit Certification/Prior Authorization is required prior to obtaining care from a National Network Provider outside of New Mexico. If Benefit Certification/Prior Authorization is not obtained when required, then the services will not be covered by the Plan and payment will be your responsibility.**

Out-of-Network

Note: You are responsible for obtaining any required Prior Authorization prior to receiving services from Out-of-Network Providers, Practitioners, and/or facilities.

- Services received from providers and or facilities that are not in the LoboCare Network or not contracted with your TPA.
- Payments by the Plan for Covered Services will be limited to Reasonable and Customary Charges.
- You will be responsible for any balance due above the Reasonable and Customary Charges, in addition to any applicable Deductibles or Coinsurance. Reasonable and Customary Charges are defined in the *Glossary of Terms* Section of this PBB.
- If an In-Network Provider/Practitioner recommends or refers you to an Out-of-Network Provider/Practitioner, services from that Out-of-Network Provider/Practitioner are subject to the Out-of-Network benefits as shown in the *Schedule of Benefits*.
- Out-of-Network Providers/Practitioners may require you to pay them directly at the time of service. You will then have to file your claim for reimbursement with your TPA's Claims Office.
- Some services are not covered when received from Out-of-Network Providers/Practitioners. Please refer to your *Schedule of Benefits* and throughout this PBB for a complete listing of Covered Services.

NOTE:

If you obtain Covered Services from LoboCare Providers or In-Network Providers/Practitioners, you will not have to file any claims. LoboCare and In-Network Providers/Practitioners will bill your TPA directly for any Covered Services you obtain from them.

HOW THE PLAN WORKS

Benefit Certification/Prior Authorization

What Is Required?

Certain services and supplies are covered only if they are Certified/Authorized. Benefit Certification/Prior Authorization means the process whereby your TPA or your TPA's delegated Provider contractor reviews and approves in advance the provision of certain Covered Services to Participants before those services are rendered. **If services requiring Benefit Certification/Prior Authorization are received from Out-of-Network Providers/Practitioners and Benefit Certification/Prior Authorization was not obtained, you will be responsible for the resulting charges**. Services rendered beyond the scope of the **Benefit Certification/Prior Authorization** are **not covered.**

Who Is Responsible?

Benefit Certification/Prior Authorization of services or supplies rendered by LoboCare or In-Network Providers/Practitioners in New Mexico is the responsibility of the LoboCare or In-Network Provider/Practitioner. Participants will not be liable for charges resulting from the failure of the LoboCare or In-Network Provider/Practitioner to obtain such required Benefit Certification/Prior Authorization. All Benefit Certification/Prior Authorizations are provided by a Medical Director or the Medical Director's designee.

National Network Providers outside New Mexico: You are responsible for ensuring Benefit Certification/Prior Authorization requirements are met prior to receiving services from a National Network provider outside New Mexico. **If Benefit Certification/Prior Authorization is not obtained when required, then the services will not be covered by the Plan**.

When accessing Out-of-Network benefits, you are responsible for ensuring Benefit Certification/Prior Authorization has been obtained before obtaining the Out-of-Network services. **If Benefit Certification/Prior Authorization is not obtained when required, then the services will not be covered by the Plan**.

NOTE:
If you lose coverage under this Plan, **services received after coverage ends will not be covered**, even if Benefit Certification/Prior Authorization was obtained. Obtaining Benefit Certification/Prior Authorization does not guarantee the services you receive will be covered by your Plan.

What Services and Supplies Require Benefit Certification/Prior Authorization?

The Benefit Certification/Prior Authorization process and requirements are regularly reviewed and updated based on various factors including: medical trends, Provider/Practitioner participation, state and federal regulations, and your TPA's own policies and procedures acting on behalf of the Plan. Your LoboCare or In-Network Provider/Practitioner will know when Benefit Certification/Prior Authorization is

necessary. If you receive the following services from an Out-of-Network Provider, you are responsible for ensuring your Out-of-Network Provider/Practitioner requests Benefit Certification/Prior Authorization from your TPA or you may be required to request Benefit Certification/Prior Authorization. Discuss the need for **Benefit Certification/Prior Authorization** with your Provider/Practitioner before obtaining any of the following services:

- Autism Spectrum Disorder.
- Bone growth stimulators.
- Clinical Trials (Investigational/Experimental) as specified in the *Covered Services* Section.
- CT scans.
- Custom ankle-foot orthosis.
- Dental-related services or accidental injury to teeth.
- Durable Medical Equipment – certain service/equipment may require Benefit Certification/Predetermination; contact your TPA for a complete list.
- Gender Reassignment Services.
- Genetic Testing and Counseling.
- Genetic Inborn Errors of Metabolism treatment.
- Home health services/home health intravenous drugs.
- Hospice Care.
- Hospital admissions, Inpatient non-emergent.
- Injectable drugs.
- Medical detoxification.
- Mental Health services.
- Magnetic Resonance Imaging (MRIs) and Magnetic Resonance Angiography (MRAs).
- Nuclear Medicine.
- Organ transplants.
- PET (Positron Emission Tomography) scans.
- Prosthetics.
- Reconstructive and potentially cosmetic procedures.
- Residential Treatment Center.
- Skilled-nursing facility care.
- Substance Use services, Inpatient.

- Chemotherapy.
- Cardiac and Pulmonary Rehab.
- Nuclear Medicine.
- Outpatient Surgery.
- Radiation therapy.

If a request for Benefit Certification/Prior Authorization is made and not approved, you and your Provider/Practitioner will be notified of the adverse determination by telephone (or as required by the medical exigencies of the case), within 24 hours after making the determination. You and your Provider/Practitioner will also be notified of the adverse determination by written or electronic communication sent within one working day of a telephone notice.

Please see the *Filing Claims* Section under "Appeal and Grievance Procedures" for information regarding the request for review of any adverse determination.

No Need to File Claim Forms When You Visit an In-Network Provider/Practitioner

You will not be required to fill out claim forms or file claims for Covered Services obtained from providers contracted with your TPA. LoboCare and In-Network providers will bill your TPA directly. You will be required to pay any applicable Deductible, Coinsurance, and/or Copay at the time you receive services. The amount of your responsibility for each service can be found in your *Schedule of Benefits.*

Annual Plan Year Deductible and Out-of-Pocket Maximum

Annual Plan Year Deductible

The LoboCare Network Benefit level and the In-Network benefit level have a combined Annual Plan Year Deductible. Some services for both LoboCare Network and In-Network are subject to that Combined Annual Plan Year Deductible. Services at the Out-of-Network level are subject to a separate Annual Plan Year Deductible. The amount of your Annual Plan Year Deductible can be found in your *Schedule of Benefits.*

Annual Plan Year Deductible amounts for the (combined) Lobocare/ In-Network and/or the separate Out-of-network level must be paid for by a Participant each Annual Plan Year toward Covered Services requiring Coinsurance before health benefits for that Participant are paid by the Plan.

The Annual Plan Year Deductibles are Accumulated as Follows:

- For Single or Double (two enrolled Participants) coverage, the Annual Plan Year Deductible requirement is fulfilled when the covered Participant(s) have each met

his/her **Individual Deductible**, listed in the *Schedule of Benefits*, during the Annual Plan Year.

- For Family coverage, with **three or more** enrolled Participants, the Family Deductible requirement is fulfilled **when combined services for all** covered Participants and/or Dependents has met **the Family Deductible**, listed in the *Schedule of Benefits*. **Each Participant of the family does not need to meet more than the Individual Deductible to satisfy the Family Deductible requirement**.

Annual Plan Year Deductibles for combined LoboCare/In-Network services are accumulated separately from Out-of-Network services and do not cross apply.

Annual Plan Year Out-of-Pocket Maximum

This Plan includes an Annual Plan Year Out-of-Pocket Maximum amount to help protect you from catastrophic healthcare expenses. After your Annual Plan Year Out-of-Pocket Maximum is reached in an Annual Plan Year, the Plan pays 100%, for Covered Services for the remainder of that Annual Plan Year, up to the maximum benefit amounts, if any. Out-of-Network maximums are subject to Reasonable and Customary charges. Refer to your *Schedule of Benefits* for the Annual Plan Year Out-of-Pocket Maximum amounts.

Annual Plan Year Out-of-Pocket Maximum Amounts for All Three Networks of Care are Calculated as Follows:

- For Single or Double (two enrolled Participants) coverage, the Annual Plan Year Out-of-Pocket Maximum requirement is fulfilled when the covered Participant(s) have each met his/her **Individual Out-of-Pocket Maximum** listed in *the Schedule of Benefits,* during the Annual Plan Year.
- For Family Coverage, Out-Of-Pocket Maximum is met when the aggregate total of services that are applied to the Out-Of-Pocket Maximum reach the Family Out-Of-Pocket Maximum listed in the Schedule of Benefits. No individual will meet more than individual Out-Of-Pocket Maximum. For families of three or more, it is possible to meet the family Out-Of-Pocket Maximum without an individual meeting the individual Out-Of-Pocket Maximum.

The Annual Plan Year Out-of-Pocket Maximum for LoboCare Network/In-Network includes Medical Deductible, Copays and Coinsurance for Medical Services and Prescription Drugs.

The Annual Plan Year Out-of-Pocket Maximum for Out-of-Network services includes Medical Coinsurance only. It does not include the Deductible and Prescription Drug Copays and Coinsurance. The Annual Plan Year Out-of-Pocket Maximums **do not** include non-covered charges. **You are responsible for notifying your TPA when you have reached the Annual Plan Out-of-Pocket Maximum**. **Annual Plan Year Out-of-Pocket**

Maximums for combined LoboCare/In-Network are accumulated separately from Out-of-Network services and do not cross-apply.

Lifetime Benefit Maximums, Pre-Existing Condition Exclusions

This Plan does not contain pre-existing condition exclusions. There are no lifetime benefit maximums for this Plan unless listed within this PBB.

Utilization Management Procedures (Care Coordination Services)

Your TPA's Care Coordination Department is staffed with registered nurses that coordinate Covered health services for Participants with ongoing or complex diagnoses. The role of the nurse care coordinator is to provide you support and education, so you are able to make informed healthcare decisions. Ongoing communication and visits to Participants who may have chronic illness can trigger prompt intervention and help in the prevention of avoidable episodes of illness.

As part of our Benefit Certification/Prior Authorization review process, TPA nurses evaluate your insurance claims to make sure the care you receive is Medically Necessary and part of your benefit package.

Transitional Care

Certain Covered Services may be paid at the applicable Participating Provider benefit level if the Participant is currently under a treatment plan by a provider or other healthcare provider or facility that was a member of this Plan's previous Network but who is not a member of this Plan's current Network. In order to ensure continuity of care for certain medical conditions already under treatment, the Participating Provider benefit level may continue for 180 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

(1) Cancer if under active treatment with chemotherapy and/or radiation therapy.

(2) Organ transplant patients if under active treatment (seeing a provider on a regular basis, on a transplant waiting list, ready at any time for transplant).

(3) If the Participant is Inpatient in the Hospital on the effective date.

(4) Post-acute Injury or Surgery within the past three months.

(5) Pregnancy in the second or third trimester and up to eight weeks postpartum.

(6) Behavioral health – any previous treatment.

(7) HIV/Aids – any previous treatment.

You or your Dependent must call your TPA prior to the effective date or within four weeks after the effective date to see if you or your dependents are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

Health Management Programs

Your TPA employs clinically trained professionals to work with you and your doctor to help enhance your quality of life by providing support for staying health, living with illness, and getting better. These professionals will help you reach optimum health through preventive health services (such as mammography and childhood immunizations) as well as with disease management for conditions such as asthma, depression, diabetes, smoking cessation, and high-risk pregnancies. If you would like more information, please contact your TPA's Customer Service Center.

Advance Directives

Advance Directives are the legal documents in which you give written instructions about your healthcare if in the future you cannot speak for yourself. You have the right to make choices about your own healthcare and the right to choose someone else to make healthcare decisions for you. Advance Directives help healthcare workers know your wishes and better serve you.

Fraud

Fraud increases the cost of healthcare for everyone. Your TPA must cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Provider/Practitioner and Participant activity.

If you suspect that a provider, Pharmacy, Hospital or other healthcare Provider/Practitioner has done any of the following listed below, please call the Provider/Practitioner 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 (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 an issue or if you think there is other suspicious activity, please contact your TPA's Fraud Hotline.

HOW THE PLAN WORKS

Important Instructions

This PBB describes your benefits, rights and responsibilities as a Participant. It also gives details on the limits placed on certain benefits, and what services are not covered at all. Please take the time to read this PBB carefully.

PARTICIPANT RIGHTS AND RESPONSIBILITIES

Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your Plan. Above all, your relationship with your Provider/Practitioner is essential to good health. We encourage open communication between you and your Provider/Practitioner.

Participant Rights

All Participants have a right to:

- Be treated with courtesy, consideration, respect, and recognition of their dignity.
- Have their privacy respected, including the privacy of medical and financial records maintained by the TPA and its healthcare Providers/Practitioners as required by law.
- Request and obtain information concerning the TPA's policies and procedures regarding products, services, In-Network Providers/Practitioners, Appeals procedures and other information about the TPA and the benefits provided.
- Request and obtain information about any financial arrangements between the TPA and its In-Network Providers/Practitioners, which might restrict treatment options or limit services offered to Participants.
- Be told the details about what is covered, maximum benefits, what is not covered, and how to obtain Benefit Certification/Prior Authorizations, when needed.
- Receive affordable healthcare, with limits on Out-of-Pocket expenses.
- Seek care from an Out-of-Network Provider/Practitioner and be advised of their financial responsibility if they receive services from an Out-of-Network Provider/Practitioner or receive services without required Benefit Certification/Prior Authorization.
- Be notified promptly of termination, decreases or changes in benefits, services, or the Provider/Practitioner network.
- Participate with treating Providers/Practitioners in making decisions about healthcare.
- Clear and candid discussion of Medically Necessary treatment options, regardless of benefit coverage or cost.
- Refuse care, treatment, or medications after the Provider/Practitioner has explained the care, treatment or other advice and possible consequences of this decision in a language that the Participant understands.
- Have adequate access to qualified healthcare professionals near where they live or work.

- Receive information from their Provider/Practitioner, in terms that they understand, including an explanation of their complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives irrespective of the TPA's position on treatment options.
- Have the explanation provided to next of kin, guardian, agent or surrogate, if available, when the Participant is unable to understand.
- Have all explanations to the next of kin, guardian, agent or surrogate recorded in the Participant's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Participant.
- Have access to services, when Medically Necessary, as determined by their treating Provider/Practitioner, in consultation with the TPA, 24 hours a day, seven days a week for Urgent or Emergency Health services, and for other health services as defined by this booklet.
- Have access to translation services for Participants who do not speak English as their first language, and translation services for hearing-impaired Participants for communication with the TPA.
- Receive a complete explanation of why services or benefits are denied, an opportunity to Appeal the decision to your TPA, the right to a secondary Appeal, and the right to request an independent external review, and to receive an answer within a reasonable time.
- Receive a Certificate of Creditable Coverage when a Participant's enrollment in this Plan terminates.
- Make complaints or Appeals regarding the TPA or the care provided.
- Continue an ongoing course of treatment for a period of at least 30 days if the Participant's Provider/Practitioner leaves the Provider/Practitioner network or if a new Participant's Provider/Practitioner is not in the Provider/Practitioner network.
- Make recommendations regarding the TPA's Participants' rights and responsibilities policy.

Participant Responsibilities

All Participants must**:**

- Review this PBB and if there are questions, contact your TPA Customer Service Center for clarification of benefits, limitations, and exclusions outlined in this booklet.
- Provide, as much as possible, information that your TPA and Providers/Practitioners need in order to provide services or care, or to oversee the quality of such care or services.

PARTICIPANT RIGHTS AND RESPONSIBILITIES

- Follow your TPA's policies, procedures, and instructions for obtaining services and care.
- Follow the plans and instructions for care that you have agreed upon with your Provider/Practitioner. A Participant may, for personal reasons, refuse to accept treatment recommended by In-Network Providers/Practitioners. An In-Network Provider/Practitioner may regard such refusal as incompatible with the continuance of the Provider/Practitioner-patient relationship and as obstructing the provision of proper medical care.
- Notify your TPA immediately of any loss or theft of his/her Identification Card.
- Refuse to allow any other person to use your Identification Card.
- Advise an In-Network Provider/Practitioner of coverage with the TPA at the time of service. Participants may be required to pay for services if they do not inform their In-Network Provider/Practitioner of their coverage.
- Pay all required Copays, Deductibles, and/or Coinsurance at the time services are rendered.
- Be responsible for the payment of all services obtained prior to the effective date of this Plan and subsequent to its termination or cancellation.
- Promise that all information given to your TPA in applications for enrollment, questionnaires, forms or correspondence is true and complete.
- Understand your health problems and participate in developing mutually agreed upon treatment goals for the best possible outcome.

COVERED SERVICES

Benefits are subject to the Copays, Deductibles, and Coinsurance listed in the *Schedule of Benefits*. Please refer to the *Limitations and Exclusions* Section, for details regarding the Limitations and Exclusions applicable to this Plan. **Any services received must be Medically Necessary to be covered**.

NOTE:
If you disagree with your TPA's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of your TPA's decision. See "Appeal and Grievance Procedures" in the *Filing Claims* Section.

Accidental Injury/Urgent Care/Emergency Health/Trauma Services

Urgent Care

Urgent Care means Medically Necessary medical or surgical procedures, treatments, or healthcare services received in an Urgent Care facility or other Provider/Practitioner's office for a condition that is not life threatening but requires prompt medical attention to prevent a serious deterioration in a Participant's health.

The Plan will reimburse for all services rendered that satisfy this definition, unless otherwise limited or excluded in this PBB.

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

Emergency Health Services

This Plan covers acute Emergency Health Services 24 hours per day, seven days per week, when those services are needed immediately to prevent jeopardy to a Participant's health. If Emergency Health Services are administered by either an In-Network or Out-of-Network Provider/Practitioner, benefits for the initial treatment are paid at the In-Network benefit level.

If you are hospitalized within 48 hours of Emergency Health Services, the entire hospitalization will be considered part of the initial treatment. The Emergency Room Copay is waived, and you are responsible for the appropriate admission Coinsurance. Once you are discharged, follow-up care received through an Out-of-Network Provider/Practitioner will be paid at the Out-of-Network benefit level.

If as a result of Emergency Health Services you are admitted to an Out-of-Network Hospital, services will be provided at the In-Network benefit level until you are medically stable and can be safely transferred to a Hospital participating in your TPA's network where you will continue to receive benefits at the In-Network benefit level. If your condition is stabilized and you choose to remain at the Out-of-Network Hospital, services will then be paid at the Out-of-Network benefit level.

Your TPA will provide reimbursement when you, acting in good faith, obtain Emergency Health Services for what reasonably appears to you, acting as a reasonable layperson, to be an acute condition that requires immediate medical attention, even if your condition is subsequently determined to be non-emergent.

In determining whether you acted as a "reasonable layperson" as described above, your TPA will consider the following factors:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment.
- The time of day the care was provided.
- The presenting symptoms.
- Any circumstance that prevented you from using established procedures for obtaining Emergency Health Services.

Benefit Certification/Prior Authorization is not required for Emergency Health Services.

For Emergency Health Services, you may seek Emergency Health Services from the nearest appropriate facility where Emergency Health Services can be rendered. These services will be covered as In-Network Services. Non-emergent follow-up received from an Out-of-Network Provider/Practitioner is covered as Out-of-Network services.

All Emergency Health Services, Urgent Care, and Trauma Care services are subject to the limitations listed in the *Limitations* Section and the exclusions listed in the *Exclusions* Section of this *PBB.*

Observation Services

Observation Services are defined as Outpatient services furnished by a Hospital and Provider/Practitioner 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 your condition, determine the need for a possible admission to the Hospital, or where rapid improvement of your condition is anticipated or occurs. When a Hospital places you under Outpatient observation, it is on the Providers/Practitioners written order. To transition from Observation Services to an Inpatient admission, you must meet the Level of Care criteria used by your TPA. The length of time spent in the Hospital is not the sole factor determining Outpatient Observation Service versus Inpatient Hospital stays.

Ambulance Services

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 if you require Emergency Health Services, under circumstances that would lead a reasonable layperson acting in good faith to believe that transportation in any other vehicle would endanger the patient's health. Emergency Ambulance Services are covered only under the following circumstances:

- Within your TPA's service area, to the nearest Participating Hospital where emergency medical treatment can be rendered, or to an Out-of-Network Hospital if a Participating Hospital is not reasonably accessible. Such services must be provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.
- Outside your TPA's service area, to the nearest appropriate facility where emergency medical 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.
- Your Plan will not pay more for air ambulance transportation than it would have paid for transportation over the same distance by ground transportation services, unless your condition renders the utilization of such ground transportation services medically inappropriate.
- 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.
- In determining whether you "acted in good faith" as a "reasonable layperson" when obtaining emergency Ambulance Services, your TPA will take the following factors into consideration:
  - Whether you required Emergency Health Services, as defined above.
  - The presenting symptoms.
  - Whether you as a 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 by your Provider/Practitioner or by your TPA. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Plan.

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

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

Coverage for High-Risk Ambulance Services is **limited to**:

- Air Ambulance Service when Medically Necessary. However, your Plan will not pay more for air ambulance transportation than it would have paid for transportation over the same distance by ground transportation services, unless your condition renders the utilization of such ground transportation services medically inappropriate.
- Maternity/Neonatal Ambulance Services, including ground or air-ambulance transportation to the nearest Tertiary Care facility:
  - For the medically high-risk pregnant woman with an impending delivery of a potentially viable infant; or
  - 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 Services are defined as ground or air Ambulance transportation between Hospitals, Skilled-nursing Facilities or diagnostic facilities. Inter-facility Transfer Services are covered only if they are:

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

Autism Spectrum Disorders

This Plan covers the habilitative and rehabilitative treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA). Providers must be credentialed to provide such therapy. Treatment must be prescribed by the Participant’s treating provider in accordance with a treatment plan. The treatment plan must be Certified by your TPA to determine that the services are to be performed in accordance with such a treatment plan. If services are received but were not approved as part of the treatment plan, benefits for services will be denied.

Services not Preauthorized by your TPA must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services will be denied.

Note: Habilitative treatment is defined as treatment programs that are necessary to develop, maintain, and restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered Habilitative.

Services are subject to usual Member cost-sharing features such as Deductible, Coinsurance, Copayments, and Out-of-Pocket Maximum based on place of treatment, type of service and whether Benefit Certification/Prior Authorization was obtained from your TPA. All services are subject to the *General Limitations and Exclusions* except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the Plan, including but not limited to coordination of benefits, Participating Provider agreements, restrictions on Covered Services, including review of Medical Necessity, case management, and other managed care provisions.

Regardless of the type of therapy received, claims for services related to Autism Spectrum Disorder should be mailed your TPA, **not** to the behavioral health services administrator.

Exclusions

This Plan does **not** cover:

- Any experimental, long-term, or maintenance treatments not covered under state law.
- Services that are not Medically Necessary.
- Any services received under the federal Individuals with Disabilities Education Improvement Act of 2004.
- 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 old who have Autism Spectrum Disorder.
- Respite services or care.
- Services in accordance with a treatment plan that has not been Certified by your TPA.
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT).
- Music therapy, vision therapy, or touch or massage therapy.
- Floor time.
- Facilitated communication.
- Elimination diets, nutritional supplements, intravenous immune globulin infusion and secretin infusion.
- Chelation therapy.
- Hippotherapy, animal therapy, or art therapy.

Clinical Trials

Qualified Clinical Trial Expenses: Expenses that are, except as excluded below, healthcare items and services for the treatment of cancer or any other life-

threatening condition for a qualifying individual enrolled in a qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Participant did not participate in the qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted and a “qualifying individual” means any Participant who is eligible to participate in a qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring healthcare professional or (ii) medical and scientific information provided by the Participant.

Notwithstanding the above, qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the qualified Clinical Trial.

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments.

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Clinical Trial means 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 other life-threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation 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 one of the entities described in (a) through (d) above.

(f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants.

(g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be 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.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Clinical Preventive Services

Clinical Preventive Services are covered only when provided by a LoboCare or an In-Network Provider/Practitioner if in New Mexico, or a National Network Provider if outside of New Mexico. Coverage is provided for the following Clinical Preventive Services at an age and frequency as determined by your healthcare LoboCare or In-Network Provider/Practitioner.

Preventive Physical Examinations including:

- 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 sport, school, or camp activities.
- Periodic tests to determine 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 40 years of age or older.
- 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, travel, passports or functional capacity examinations related to employment are **not covered**.

Well-Child Care in accordance with the recommendations of the American Academy of Pediatrics.

Vision and Hearing Screening to determine the need for vision and hearing correction. This does not include routine eye exams or Eye Refractions performed by eye care specialists. One Eye Refraction per Annual Plan Year is covered for children under age 17 when Medically Necessary to aid in the diagnosis of certain eye diseases.

Adult and Child Immunizations (shots or vaccines), in accordance with the recommendations of the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, or the U.S. Preventive Services Task Force. **Immunizations for the purpose of foreign travel are not covered**.

Colorectal Cancer Screening in accordance with the evidence-based recommendations established by the United States Preventive Task Force for determining the presence of pre-cancerous or cancerous condition and other health problems including fecal occult blood testing (FOBT), periodic left-sided colon examination of 35 to 60 centimeters (Flexible Sigmoidoscopy), colonoscopy and double-contrast barium enema.

Periodic glaucoma eye test

Health Education materials and consultation from Providers/Practitioners 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 Participants under 19 years of age, this includes (as deemed appropriate by the Participant's Provider/Practitioner or as requested by the parents or legal guardian) education information on Alcohol and Substance Use, sexually transmitted infections, and contraception. For Participants 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.

Smoking Cessation for information regarding Smoking Cessation programs refer to "Smoking Cessation Programs" of this Section.

Mammography Coverage for low-dose screening mammograms for determining the presence of breast cancer. Coverage includes but is not limited to, one baseline mammogram for women ages 35-39, one mammogram every two years for women ages 40-49 and one mammogram each year for women ages 50 and over.

Cytologic Screening (Pap smear screening) and Human Papillomavirus (HPV) screening to determine the presence of precancerous or cancerous conditions and other health problems. Coverage includes but is not limited to women who are 18 years of age or older and for women who are at risk of cancer or other health conditions that can be identified through Cytologic screening.

HPV Vaccine Coverage for the Human Papillomavirus, as approved by the Food and Drug Administration, for females 9 to 14 years of age used for the prevention of Human Papillomavirus infection and cervical pre-cancers. In addition, the HPV vaccine is covered for other populations ***in accordance with guidelines established*** by The Advisory Committee on Immunization Practices (ACIP).

Women's Preventive Care including but not limited to the following:

- Well-Woman Visits.
- Gestational Diabetes Screening.
- HPV DNA Testing.

- STI Counseling.
- HIV Screening and Counseling.
- Contraception and Contraceptive Counseling.
- FDA approved women's surgical sterilization procedures.
- Contraception implant insertion/reinsertion.
- Breastfeeding Support, Supplies, And Counseling.
- Interpersonal and Domestic Violence Screening and Counseling.

Complementary Therapies

The only alternative/complementary therapies that are covered are those that are identified in this PBB.

Acupuncture (Limited) Services

Acupuncture Services are available, subject to the following limitations:

- Acupuncture is specifically limited to treatment by means of inserting needles into the body to reduce pain, induce anesthesia, or for Smoking Cessation treatment. It may also be used for other diagnoses as determined appropriate by the Provider/Practitioner.
- It is recommended that Acupuncture be part of a coordinated plan of care approved by your Provider/Practitioner.
- Acupuncture services are limited to an Annual Plan Year Maximum. Refer to your *Schedule of Benefits* for this maximum. Maintenance treatment is not covered.

Chiropractic Services (Limited)
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 limitations:

- **The Provider/Practitioner determines** in advance what chiropractic treatment can be expected to result in Significant Improvement in your condition.
- 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 your TPA including, but not limited to, ultrasound therapy).
- Subluxation **must be documented** by chiropractic examination and documented in the chiropractic record. Radiologic (X-ray) demonstration of Subluxation is not a requirement of your TPA for Chiropractic Services.
- **Chiropractic X-rays are only covered** when performed by a chiropractor for the following clinical situations, unless clinically relevant X-rays already exist:

- Acute trauma with a suspected fracture, such as motor vehicle accidents or slip-and-fall accidents.
- Clinical evidence of significant osteoporosis, recent fracture of the spine, wrist or hip, loss of height over one-half of an inch, or spine curvature consistent with osteoporotic fractures.
- Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement.

Treatment of conditions, other than headaches, which do not have acute Subluxation demonstrable on exam, are not covered. This includes chronic Subluxation of rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/conditions as determined by your TPA as not meeting this definition.

No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered except as specified in this PBB.

Treatment provided beyond the point at which you are no longer making significant improvement will not be covered.

Chiropractic services are limited to an Annual Plan Year Maximum. Refer to your *Schedule of Benefits* for this maximum.

Dental Services Including Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)

Dental services will be provided in connection with the following conditions when deemed Medically Necessary except in an emergency as described in the *Covered Services* Section.

Accidental Injury to sound natural teeth, jawbones or surrounding tissue. Accidental Injury treatment is limited to initial services received within 72 hours of the date of the accident. In addition, follow-up care must begin within three months of the date of accident and be completed within one year of the date of the accident unless treatment must be delayed due to medical necessity as determined by your TPA. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury**.

Correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.

Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

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 Benefit Certification/Prior Authorization procedures as are applicable to treatment of any other joint in the body. **Orthodontic appliances and treatment (braces), crowns, bridges and dentures used for the treatment of temporo/craniomandibular joint disorders are specifically excluded, unless the disorder is trauma related. Services related to Malocclusion treatment, if part of routine dental care and orthodontics, are not covered**.

Hospitalization, day Surgery, Outpatient services and/or anesthesia for non-covered dental services are covered if provided in a Hospital or ambulatory surgical center for dental Surgery when approved by your TPA. Plan benefits for these Outpatient services include:

- For Participants 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 Participants for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
- For covered children or adolescents, who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs. These dental needs are 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 Participants 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.

Exclusions Relating to Dental Services:

Dental care and dental X-rays, except as provided in the *Covered Services* Section, hospitalization, day surgery, Outpatient services and/or anesthesia for non-covered dental services **are covered if provided in a Hospital or ambulatory surgical center for dental Surgery when approved by your TPA.**

Diabetes Services

The Plan provides Coverage for individuals with insulin dependent (Type I) diabetes, non-insulin dependent (Type II) diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). Your TPA will provide coverage for equipment and appliances. CVS Caremark will cover Prescription Drug, insulin or supplies that meet Food and Drug Administration (FDA) approval, and are the medically accepted standards for diabetes treatment, supplies and education.

Diabetes Education

The following benefits are available from an approved Diabetes Educational Provider/Practitioner.

- **Diabetes self-management training limited to**:
  - Medically-necessary visits upon the diagnosis of diabetes.
  - Visits following a Provider/Practitioner 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 Provider/Practitioner with prescribing authority.
- Medical nutrition therapy related to diabetes management.

Approved Diabetes Educational Providers/Practitioners must be Certified, registered or licensed healthcare professionals with recent education in diabetes management.

Diabetes Supplies and Services. When prescribed by your Provider/Practitioner the following equipment, supplies, appliances, and services are covered for diabetes.

- Prescriptive diabetic oral agents for controlling blood sugar levels. Provided by CVS Caremark, call **1-877-745-4394** or visit **https://www.caremark.com/**.
- Medically Necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment, when certified by your TPA.
- Insulin pumps when Medically Necessary and prescribed by an endocrinologist.

For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), call CVS Caremark at **1-877-745-4394** or visit **https://www.caremark.com/**.

Diagnostic Services

(Tests performed to determine if you have a medical problem)

Coverage is provided for Diagnostic Services, when Medically Necessary and subject to the **limitations in *Limitations* Section, the exclusions in the *Exclusions* Section and the "Benefit Certification/Prior Authorization" requirements in *How the Plan Works* Section** of this PBB. All Diagnostic Services must be provided under **the direction of your Provider/Practitioner**. Examples of covered procedures include, but are not limited to the following:

- Cardiac procedures including, but not limited to, EKG, EEG, echocardiograms and a multigated acquisition (MUGA) scans.
- Clinical laboratory tests.
- Computerized Tomography (CT) scans (may require Benefit Certification/Prior Authorization).
- Endoscopy procedures.
- Gastrointestinal lab procedures.
- Magnetic Resonance Imaging (MRI) tests (may require Benefit Certification/Prior Authorization).
- Pulmonary function tests.
- Radiology/X-ray services.
- Ultrasound procedures.
- Sleep disorder studies (may require Benefit Certification/Prior Authorization).
- Bone density studies (may require Benefit Certification/Prior Authorization).

Unless otherwise noted, **Benefit Certification/Prior Authorization** is not required for the Diagnostic Services listed above.

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair And Replacement, Surgical Dressing

Durable Medical Equipment

Durable Medical Equipment is equipment that is medically necessary for treatment of an illness, accidental injury, or to prevent the patient's further deterioration. This equipment is designed for repeat use, and includes items such as oxygen equipment, wheelchairs, and crutches. Rental, or at the option of your TPA, the purchase of Durable Medical Equipment is covered when required for therapeutic use, determined to be Medically Necessary by your Provider/Practitioner, and if Certified by your TPA when required. Only Durable Medical Equipment considered standard and/or basic items are covered. **Upgraded or deluxe items are not covered**.

- Participants employed outside the home for two or more hours on a given day shall be eligible for an additional or alternative oxygen system, if medically necessary and appropriate, as determined by the TPA.

Exclusions:

- Upgraded or deluxe items.
- Items considered "for convenience." A convenience item is an appliance, device, object or service that is for the comfort and ease and is not primarily medical in nature. Examples include, but are not limited to:

- Shower stools/chairs/seats.
- Bath grab bars.
- Shower heads.
- Vaporizers.
- Wheelchair/walker/stroller accessories such as baskets, trays, seats or shades.
- Duplicate DME items (i.e., for home and for office).

Orthotic Appliances (Limited)

Orthotic Appliances include prefabricated braces and other external devices used to correct a body function including clubfoot deformity. Benefits will be provided, if determined to be Medically Necessary by your Provider/Practitioner, and if certified by your TPA. Foot orthotics or shoe appliances are **not covered**, except for Participants with diabetic neuropathy or other significant neuropathy. Custom-fabricated knee-ankle-foot orthoses (AFO and/or KAFO) are covered if medically necessary.

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 extremity 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 will be provided when determined to be Medically Necessary by your Provider/Practitioner and when certified by your TPA.

Examples of Prosthetic Devices include but are not limited to breast prostheses when required as a result of mastectomy, 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 Orthotic Devices

Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices is covered when certified by your TPA and when Medically Necessary due to a change in your condition, wear or after the product's normal life expectancy has been reached.

Exclusions Related to Repair and Replacement of Durable Medical Equipment, Prosthetics, and Orthotic Devices:

- Repair and replacement due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience.
- Repair and replacement of items under the manufacturer or supplier's warranty.

- If the Participant has a functional wheelchair, regardless of the original purchaser of the wheelchair, additional wheelchair(s) are not covered. One-month rental of a wheelchair is covered if a Participant owned the wheelchair that is being repaired.

Surgical Dressing

Surgical dressings, which require a Provider/Practitioner'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 up to **two pairs per Annual Plan Year 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 Provider/Practitioner or other healthcare professional requiring Medically Necessary debridement (wound cleaning).

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

Exclusions related to Surgical Dressings:

- Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze (such as 4 x 4s) and ace bandages, except when provided in a Hospital or Provider/Practitioner's office or by a home health professional.
- Gloves unless part of a wound treatment kit.
- Elastic support hose.

Eyeglasses/Contact Lenses And Hearing Aids

Eyeglasses and Contact Lenses (Limited)

All eyeglasses or contact lenses are **subject to the limitations in the Limitations Section and exclusions in the Exclusions Section of this Participant Benefit Booklet**.

- Contact lenses are covered for the correction of aphakia (those with no lens in the eye) or kerataconus. 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.

Exclusions relating to Eyeglasses and Contact Lenses:

- Except as above, routine vision care, Eye Refraction's, corrective eyeglasses, sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof.
- Routine vision care and Eye Refractions for determining eyeglass or contact lens prescriptions.
- Eye refractive procedures including radial keratotomy, laser procedures, and other techniques.
- Visual training.

Hearing Aids

Hearing Aids and the evaluation for the fitting of Hearing Aids.

- Up to $2,500 every 36 months "per hearing-impaired ear".
- Shall include hearing exam, fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by an In-Network Provider/Practitioner licensed in New Mexico.

Family, Infant And Toddler (Fit) Program

Coverage for children, from birth to age 3, 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. These services are provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title seven, Chapter 30, Part eight Health, Family and Children Healthcare Services. Benefits used under this Section will not be applied to any maximum lifetime or annual plan limits applicable to this Plan. This benefit is subject to an annual maximum. Refer to your *Schedule of Benefits* for the dollar amount maximum.

Genetic Inborn Errors of Metabolism Disorders (IEM)

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 and Exclusions* Section, and Benefit Certification/Prior Authorization in the *How the Plan Works* Section requirements listed in the PBB. Medical services provided by licensed healthcare professionals, including Providers/Practitioners, dieticians and nutritionists, with specific training in managing Participants diagnosed with Genetic Inborn Errors of Metabolism (IEM) are covered. Covered Services include:

- Nutritional and medical assessment.
- Clinical services.

- Biochemical analysis.
- Medical supplies.
- Corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM).
- Nutritional management.

Exclusions:

- Food substitutes for lactose intolerance including soy foods or formulas, or other over-the-counter digestive aids.
- Organic foods.
- Ordinary foodstuffs that might be part of an exclusionary diet.
- Food substitutes that do not qualify as Special Medical Foods.
- Any product that does not require a Provider/Practitioner's prescription.
- Special Medical Foods for conditions that are not present at birth.
- Food items purchased at a health food, vitamin or similar store.
- Foods purchased on the Internet.
- Special Medical Foods for conditions including, but not limited to diabetes mellitus, hypertension, hyperlipidemia, obesity, and allergies to food products.

For prescription drug and special medical food coverage, contact **CVS Caremark** at **1-877-745-4394** or visit **https://www.caremark.com/**. Please refer to your *Schedule of Benefits* for applicable office visit, Inpatient Hospital, Outpatient facility, and other related Copays.

Home Healthcare Services/Home Intravenous Services and Supplies

Home Healthcare Services are services provided to a Participant confined to the home due to physical illness. **Private-duty nursing is not covered**. A Home Health Agency will provide Home Intravenous Services and Supplies at your home when certified by your TPA and when prescribed by a LoboCare or In-Network Provider/Practitioner. Any such prescription or Benefit Certification/Prior Authorization must be renewed at the end of each 60-day period. Your TPA will not impose a limitation on the number of related hours per visit.

- **Home Healthcare Services are covered up to 100 visits per Annual Plan Year**. Home Healthcare 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 pathologists. Intermittent home health aide services are covered only when part of an approved plan of care that includes Medically Necessary skilled services. **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 Healthcare benefits. **Examples of Custodial Care that are not covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks**.

- Medical equipment, drugs and medications, and supplies deemed Medically Necessary by an In-Network Provider/Practitioner for the provision of health services in the home, **except Durable Medical Equipment**.
- Home Healthcare Services or Home Intravenous Services as an alternative to hospitalization, as determined by the Participant's In-Network Provider/Practitioner and as approved by your TPA.
- Total parenteral and enteral nutrition as the sole source of nutrition, when certified by your TPA.
- **Home Healthcare Services are limited to an Annual Plan Year Maximum of 100 visits**.

Hospice Care

(Where a Certified Hospice program is available)

If you become terminally ill, Inpatient and In-home Hospice Care are Covered Services when services are provided by a Hospice program approved by your TPA during a Hospice benefit period **(and not covered to the extent that they duplicate other Covered Services available to you)**. Benefits are provided for a participating Hospice or other facility when approved by your Provider/Practitioner and Certified by your TPA. The Hospice benefit period must begin while you are enrolled in this Plan, and coverage through your TPA must be continued throughout the benefit period in order for Hospice Care benefits to continue.

The Hospice benefit period is defined as:

- Beginning on the date your Provider/Practitioner certifies that you are terminally ill with a life expectancy of six months or less.
- Ending six months after it began, except as described below, or upon the death of the Participant.
- If you require an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and your Provider/Practitioner must re-certify your medical condition. No more than one additional Hospice benefit period will be certified by your TPA.

The following services will be covered under the Hospice Care benefit, where a certified Hospice program is available:

- Inpatient Hospice Care.

- Provider/Practitioner visits by an In-Network Hospice Provider/Practitioner.
- Home healthcare Services by approved home healthcare personnel.
- Physical therapy.
- Medical supplies.
- Drugs and medication for the pain and discomfort specifically related to the terminal illness.
- Medical transportation (facility to facility for Inpatient Hospice benefits only).

Hospice Care benefits are not covered for the following services:

- Food, housing, and delivered meals.
- Volunteer services.
- 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).
- Homemaker and housekeeping services.
- Private-duty nursing.
- Pastoral and spiritual counseling.
- Bereavement counseling.
- Respite Care.

The following services are not covered under Hospice Care, but may be covered elsewhere in this PBB subject to your Deductible, Copay and Coinsurance requirements:

- Acute Inpatient Hospital care for curative services.
- Durable Medical Equipment.
- Provider/Practitioner visits by someone other than an In-Network Hospice Provider/Practitioner.
- Ambulance Services.

Where there is not a certified Hospice program available, regular Home Healthcare Services benefits will apply. Refer to the *Covered Services* Section “Home Healthcare Services/Home Intravenous Services and Supplies” of this PBB.

Hospice Care Services through LoboCare are limited to pediatric Hospice only.

Before you receive Hospice Care, the treating Provider/Practitioner or Hospice agency must request **Benefit Certification/Prior Authorization in writing** from the Participant’s TPA. **Benefit Certification/Prior Authorization** requires a written

treatment program approved by the treating Provider/Practitioner. In-Network Providers/Practitioners request **Benefit Certification/Prior Authorization** for you.

Hospital Admissions – Inpatient services

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

Hospital admissions must be certified by your TPA, unless such services constitute Emergency Health Services. Hospital services must be provided under the direction of the Participant's Provider/Practitioner.

Inpatient Hospital services include, but are not limited to the following when Medically Necessary, **subject to the Benefit Certification/Prior Authorization requirements listed in the *How the Plan Works* Section, the limitations contained in the *Limitations* Section and the exclusions contained in the *Exclusions* Section**:

- Acute Medical Detoxification: Inpatient treatment for acute medical detoxification induced by alcohol or drug use disorder shall be provided when medically necessary at an acute-care facility or a treatment center specializing in Substance Use. Acute Medical Detoxification treatment must be approved in advance by the Participant's Provider/Practitioner and must be certified by your TPA. **Acute Medical detoxification does not include rehabilitation**.
- Anesthetics, oxygen, and covered medications.
- Diagnostic Services, as specified in the *Covered Services* Section.
- Dressings, casts and special equipment when supplied by the Hospital for use in the Hospital.
- Facilities: Use of operating, delivery, recovery and treatment rooms and equipment and all other facilities.
- Meals and special diets or parenteral (intravenous) nutrition.
- Provider/Practitioner and surgeon services.
- Private room and board accommodations when medically necessary and Certified by your TPA.
- Semi-private room and board accommodations, including general duty nursing care.
- Special services and procedures, such as special duty nursing, when certified by your TPA.

- Surgery, when Certified by your TPA. Cosmetic Surgery is not covered. Examples of Cosmetic Surgery include, but are not limited to, breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except when used for truncal veins), and nasal rhinoplasty.
- Therapeutic and support care: Services, supplies, appliances, and therapies including care in specialized intensive and coronary care units, radiation therapy and inhalation therapy.
- Physical Rehabilitation: Inpatient benefits are available for inpatient rehabilitation services that are Medically Necessary to restore and improve lost functions following illness or Accidental Injury and are provided in Participating facilities.
  - Hospitalization for rehabilitation must begin within one year after the onset of the condition and while the Participant is covered under this Plan.
  - Inpatient rehabilitation must be Medically Necessary and not for personal convenience.
  - Benefits are not available for care that is not provided by a Participating facility.
  - These Inpatient services are not eligible for any additional benefits on an Outpatient basis.
  - There are no benefits for Maintenance Therapy or care provided after the patient has reached his/her rehabilitative potential. The patient is responsible for furnishing documentation from the treating Provider supporting that the patient's rehabilitative potential has not been reached.

Medical Evacuation Reimbursement

Reimbursement of expenses for common carrier transportation and reasonable food and lodging in connection with a medical evacuation (world-wide) may be covered. Benefits are available if:

- You become sick or injured while covered under this Plan, and in the discretion of your TPA and your attending Provider/Practitioner, you are required to be taken to:
  - the nearest medical facility where appropriate medical treatment can be obtained.
  - a medical facility in your home country.
- The medical evacuation is ordered by a treating Provider/Practitioner who certifies that the severity of the sickness or injury necessitates the medical evacuation, and you agree.
- You obtain **Benefit Certification/Prior Authorization** for the method of transportation in advance. Please contact your TPA Customer Service Center to determine if Benefit Certification/Prior Authorization is required.

Note: Benefits are limited to $50,000 per Covered Participant during the time the Plan is in force. Benefit Certification/Prior Authorization must be obtained from your TPA, prior to being transported. If Benefit Certification/Prior Authorization is not received prior to being transported, the Participant will be responsible for all charges.

Mental Health, Alcoholism And Substance Use

Mental Health Services

You may obtain mental health-related services from a LoboCare Provider/Practitioner or In-Network Provider/Practitioners directly. The participating behavioral health Providers/Practitioners will be responsible for any additional Benefit Certification/Prior Authorization. For National Network or Out-of-Network services, you must contact your TPA's Behavioral Health Department or your TPA's designee in order to obtain Benefit Certification/Prior Authorization.

If Mental Health services are not Certified when required, they are **not covered**.

- Acute Inpatient Mental Health Services will be covered when Certified by your TPA or your TPA's designee. Coverage is provided for Inpatient mental health and partial hospitalization.
- Partial hospitalization can be substituted for the Inpatient mental health services when Certified by your TPA or your TPA's designee. Partial hospitalization is a non-residential, Hospital-based day program that includes various daily and weekly therapies.
- Outpatient, non-hospital based evaluative and therapeutic mental health services will be provided when deemed Medically Necessary and Certified by your TPA or your TPA's designee.
- Acute medical detoxification benefits are covered under Inpatient and Outpatient Medical Services found in the *Covered Services* Section of this *PBB.*

Exclusions

In addition to the exclusions listed in the *Exclusions* Section of this *PBB*, the following are **not covered**:

- Co-dependency treatment.
- Sex, pastoral/spiritual, and bereavement counseling.
- Psychological testing when not Medically Necessary.
- Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or behavioral problems. This applies whether or not associated with manifest mental illness or other disturbances.

- 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.
- Alcohol and/or Substance Use Services are not considered mental health benefits.

Alcohol and Substance Use Services

Please check Alcohol and Substance Use Services included with the PBB for the applicable Copay/Coinsurance amount for these services.

The following benefits and limitations are applicable for Alcohol and Substance Use Services. In all cases, treatment must be Medically Necessary in order to be covered.

- To obtain Alcohol and Substance Use Services, Participants may contact your TPA or your TPA's designee. The Behavioral Health Provider/Practitioner will be responsible for any additional Benefit Certification/Prior Authorizations.
- The following limitations apply:
  - Inpatient treatment in a Hospital or Substance Use treatment center will be covered when Certified by your TPA or your TPA's designee.
  - Partial hospitalization can be substituted for Inpatient Alcohol and Substance Use Services if Certified by your TPA or your TPA's designee. Partial hospitalization is a non-residential day program, attended by the patient at eight hours a day, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days shall be the equivalent of one day of Inpatient.
  - Intensive and standard Outpatient evaluative and therapeutic services for Alcohol and Substance Use will be provided if Certified by your TPA or your TPA's designee. Intensive Outpatient Alcohol and/or Substance Use services are defined as visit lasting three hours per visit and attended by the Participant three times per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting up to 50 minutes.
- Acute Medical Detoxification Benefits are covered under Inpatient and Outpatient Hospital Services found in the *Covered Services* Section "Hospital Admission – Inpatient" and "Outpatient Medical Services".

Exclusions

In addition to the exclusions listed in the PBB, the following are not covered.

- Treatment in a halfway house.
- Co-dependency treatment, sex, pastoral/spiritual, and bereavement counseling.
- Court-mandated treatment, treatment that is a condition of parole or probation or in lieu of sentencing.

Nutritional Support and Nutritional Supplements

For information about Covered Services, contact CVS Caremark. Call CVS Caremark at **1-877-745-4394**.

Outpatient Medical Services

Outpatient Medical Services are administered at a medical facility such as a Hospital or doctor's office after which the Participant goes home without being admitted to the facility.

Outpatient Medical Services include reasonable Hospital services provided on an ambulatory basis, and preventive, Medically Necessary, diagnostic and treatment procedures that are prescribed by the Participant's attending Provider/Practitioner, subject to the Benefit Certification/Prior Authorization requirements listed in the ***How the Plan Works*** **Section under "Benefit Certification/Prior Authorization," the limitations listed in the *Limitations* Section and the exclusions listed in *Exclusions* Section of this Participant Benefit Booklet**.

Such services may be provided in a Hospital, Provider/Practitioner's office, any other appropriate licensed facility, or any other appropriate facility if the professional delivering the service is licensed to practice, is certified, and is practicing as authorized by applicable law or authority of your TPA. These services may also be provided by a medical group, an independent practice association or other authority authorized by applicable law or authority, and includes the following:

- Anesthetics, oxygen, drugs, and medications.
- Blood, blood plasma and blood components.
- Chemo and radiation therapy.
- Diagnostic Services, as specified in the *Covered Services* Section under "Diagnostic Services."
- Dressings, casts and special equipment when supplied by the Hospital for use in the Hospital.
- Facilities: Use of operating, recovery and treatment rooms and equipment.
- Medical Detoxification: Medically Necessary services for Alcohol and Substance Use detoxification.
- Observation Services as defined in the *Covered Services* Section under "Observation Services."
- Sleep disorder studies.
- Surgeries, including use of, operating, delivery, recovery, and treatment rooms, and equipment and supplies, including anesthesia, dressings and medications.
- Therapeutic and support care services, supplies, appliances, and therapies.

COVERED SERVICES

Provider/Practitioner Services

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

- A licensed Provider.
- Specialist services provided by other healthcare professionals who are licensed to practice, are certified, and are practicing as authorized by applicable law or authority.
- A Medical Group.
- An independent practice association.
- Other authority authorized by applicable state law.

The Provider/Practitioner Services, covered by this Section are **subject to the Benefit Certification/Prior Authorization requirements contained in the *How the Plan Works* Section under "Benefit Certification/Prior Authorization," the limitations contained in *Limitations* Section and the exclusions listed in *Exclusions* Section of this Participant Benefit Booklet**. This Plan covers consultation, healthcare services and supplies provided by the Participant's Provider/Practitioner including:

- Office visits provided by a qualified Provider/Practitioner. Services of a Provider/Practitioner for the diagnosis and treatment for mental illness or Substance Use shall be provided according to the *Covered Services* Section under "Mental Health, Alcohol and Substance Use."
- Home visits, if medically necessary.
- Outpatient Surgery and Inpatient Surgery including necessary anesthesia services by a qualified Provider/Practitioner.
- Hospital and skilled-nursing home visits by Provider/Practitioners as part of continued supervision of covered care.
- FDA-approved injections in accordance with accepted medical practice, **except those specifically limited and/or excluded in the *Covered Services* Section under "Covered Medications" and "Prescription Drug Benefit-Outpatient."**
- Family planning/**infertility** services:
  - FDA-approved Contraceptive devices and prescription medications **excluding Over-the-counter items and Investigational devices/ medications**.
  - Sterilization procedures. **Reversal of voluntary sterilization is not covered**.
  - Infertility diagnosis and treatment for physical conditions causing infertility is limited to surgery to open obstructed tubes, epididymis or vasectomy when not

the result of sterilization and replacement of deficient hormones if there is documented evidence of a deficiency. **Artificial insemination is not covered. Donor sperm is not covered. In-vitro, GIFT and ZIFT fertilization are not covered**. **Reversal of voluntary sterilization is not covered**.

- Elective abortions as identified under the "Women's Healthcare" of this Section.

- Second medical opinions. The office visit Deductible, Copay and Coinsurance will not apply if your TPA requires a second opinion to evaluate the medical appropriateness of a diagnosis or service. **The office visit Deductible, Copay and Coinsurance will apply when you or your Provider/Practitioner requests the second opinion**.

Covered Medications

Medications are covered when administered at an Inpatient, Outpatient, office, or Home Health settings.

Prescription Drugs

Are administered by CVS Caremark. Call **1-877-745-4394** or visit **https://www.caremark.com/** for assistance.

Radiological Services

X-ray, Lab, and diagnostic tests other than Magnetic Resonance Imaging (MRI) scans, Computed Axial Tomography (CAT) scans, Positron Emission Tomography (PET) scans or Nuclear Medicine are included in the office visit Copay when services are received from a participating provider.

Services for Magnetic Resonance Imaging (MRI) scans, Computed Axial Tomography (CAT), Positron Emission Tomography (PET), and Nuclear Medicine are subject to the Copay and/or coinsurance requirements as indicated in the *Schedule of Benefits* and may require Benefit Certification/Prior Authorization.

Reconstructive Surgery

Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be provided if performed for the correction of functional disorders. Your Provider/Practitioner must prescribe Reconstructive Surgery and Benefit Certification/Prior Authorization must be obtained. For information regarding Reconstructive Surgery following a Mastectomy, refer to "Women's Healthcare" of this Section.

Cosmetic Surgery is not covered. Examples of Cosmetic Surgery include but are not limited to breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy, and nasal rhinoplasty.

Therapy services

Cardiac Rehabilitation Services

Coverage is provided for 36 visits per Participant per Annual Plan Year. **Long-term rehabilitation is not covered**.

Chemotherapy/Dialysis/Radiation Therapy

Benefits are available for the following Inpatient or Outpatient therapeutic services:

- Treatment of malignant disease by standard chemotherapy.
- Treatment for removal of waste materials from the body, including renal dialysis, hemodialysis, or peritoneal dialysis, and the cost of equipment rentals and supplies.
- Treatment of disease by X-ray, radium, or radioactive isotopes.

Physical, Occupational and Speech Therapy

Benefits are limited (as shown in the *Schedule of Benefits*) for Outpatient rehabilitation services including physical therapy from a licensed physical therapist, and occupation or speech therapy from a licensed or certified therapist. Benefits are not available for speech therapy in connection with learning disabilities.

These services may also include treatment using cold, heat, or similar modalities to relieve pain, restore maximum function, and prevent disability following illness, accidental injury, or loss of a body part. Benefits are not available for Maintenance Therapy or any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the services is provided by a licensed or registered Provider.

Note: If you disagree with your TPA's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of your TPA's decision. See "Appeal and Grievance Procedures" in the *Filing Claims* section.

Short-term Rehabilitation Services

Short-term Rehabilitation benefits are available for physical therapy and occupational therapy, provided in a Rehabilitation Facility, Skilled-nursing Facility, Home Health Agency, or Outpatient setting. Short-term Rehabilitation is designed to assist Participants in restoring functions that were lost or diminished due to a specific episode

of illness or injury (i.e., stroke, motor vehicle accident, or heart attack). **Coverage is subject to the following limitations**:

- Outpatient physical therapy, occupational therapy, and speech therapy coverage up to 70 visits combined per Annual Plan Year (if determined medically necessary, additional visits may be approved).
- Treatments delivered by athletic trainers **are not** covered.

Outpatient Speech Therapy

Outpatient Speech Therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Outpatient Speech Therapy is covered when provided by a licensed or certified speech therapist.

Outpatient Speech Therapy will be covered **only** for the following conditions:

- When speech or swallowing loss is due to or caused by the following:
  - Cleft palate.
  - Never speaking, (when physical development is normal, but the child is mute, or speech is not understandable).
  - Speech disorders secondary to brain inflammation or infection.
  - Brain oxygen deprivation (anoxia).
  - Head injury.
  - Facial deformities.
- Delayed speech in children will be covered only for the following:
  - Failure to grow normally with significant language delay under age five.
  - Infants with failure to suck resulting in lack of sufficient oral muscular strength for beginning speech.
  - Children with chronic or recurring otitis media with demonstrable hearing loss.
  - Neurologically impaired children with documented diagnosed disorders of the nervous system.
- Myofunctional therapy (tongue thrust) post injury/illness will be covered in conjunction with Speech Therapy.

Outpatient Speech Therapy for stuttering is not covered.

No additional benefits are available for speech therapy.

Speech Therapy provided in an Inpatient setting such as but not limited to Rehabilitation Facilities, Skilled-nursing Units, Home Health, or intensive day-Hospital programs delivered by Rehabilitation Facilities, are not subject to the time limitation requirements of

the Outpatient therapies outlined above and are not combined with Outpatient services when calculating the total accumulated benefit usage.

Pulmonary Rehabilitation Services

Coverage is provided for 24 sessions of progressive exercises and monitoring of pulmonary functions per Participant per Annual Plan Year.

Long-term Rehabilitation Services are not covered. Therapies are considered long-term when you:

- Have reached maximum rehabilitation potential.
- Have reached a point where Significant Improvement is unlikely to occur.

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, unless otherwise noted in this PBB.

- **Vocational Rehabilitation Services are not covered**.
- **Athletic trainers are not covered**.
- **Inpatient Rehabilitation Services are not covered**.

Repatriation Reimbursement

Reimbursement of expenses in connection with the transportation of the body of a deceased Covered Participant. Benefits are available if a Participant dies while covered under this Plan; and:

- While away from your home state (permanent residence), if you are a United States citizen or resident alien; or
- While away from your home country (permanent residence), if you are a foreign Covered Participant.

Benefits are limited to $25,000 per deceased Participant and are payable only for expenses in connection with:

- The collection, storage, and preparation of the body (including embalming, cremation, or other preparation method).
- A container appropriate for storage/transportation (i.e., urn, casket, etc.), limited to a maximum of the expenses for a container that meets the minimum Federal requirements for transportation of bodily remains.

- Transportation of the remains from the mortuary (or similar facility) closest to where death occurred to a mortuary (or similar facility) in the deceased Covered Participant's home country. All transportation must be Certified by your TPA in advance.

In the case of cremation of the remains, benefits will be paid for transportation of one person who travels with the urn or other similar transportation/storage vessel in his or her possession, in lieu of benefits for transportation of the urn or other similar transportation/storage vessel. Otherwise, no benefits will be provided for the transportation of any person (including a family member) to accompany the remains during transportation.

You or your representative must notify your TPA and obtain Benefit Certification/Prior Authorization of the method of transportation before arranging the transportation. If you do not obtain Benefit Certification/Prior Authorization prior to arranging transportation, you will be responsible for all charges and no benefits will be paid by the Plan. Benefit Certification/Prior Authorization is for the reimbursement only. The Participant or Participant's designee is solely responsible for arranging travel or transport of the deceased Participant or the deceased Participant's remains.

Skilled-Nursing Facility Care

Room and board and other necessary services furnished by a Skilled-nursing Facility will be provided if you require skilled-nursing care of the type provided by the facility. Admission to the facility must be arranged and Certified by your TPA and by the Participant's Provider/Practitioner. Admission must be appropriate for your Medically Necessary care and rehabilitation. **Skilled-nursing Facility care is provided for up to 60 days per Participant, per Annual Plan Year**. **Custodial or Domiciliary Care is not Covered**.

Smoking Cessation

Coverage is provided for Diagnostic services, smoking cessation counseling, hypnotherapy 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 an In-Network Provider/Practitioner's office is covered under the medical benefit. The office-visit Copay applies. There is no limit to the number of visits that are covered. **Out-of-Network Providers/Practitioners are not covered**.
- Employer Counseling, including classes or a telephone "quit line" are covered through an In-Network Provider/Practitioner. No Copay 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 Employer-counseling services at no charge. Participants may want to utilize these services. (Contact your TPA's Customer Service Center for a list of programs).

Pharmacotherapy Benefits

- Benefits are limited to Prescription Drugs purchased at a Participating Pharmacy and **are administered by CVS Caremark**. **Call 1-877-745-4394 for information**.

Exclusions:

- Over-the-counter drugs.
- Acupuncture for smoking cessation counseling is not covered under the smoking cessation counseling benefit. Refer to Complementary Therapies in the *Covered Services* Section of this PBB for benefits available under the Acupuncture Benefit.

Transplants

- Human organ transplant benefits are available for cornea, heart, heart/lung, lung, intestinal, kidney, liver, pancreas, and pancreas islet cell infusion. Bone marrow transplants are **covered only for leukemia, aplastic anemia, lymphoma, severe combined immunodeficiency disease (SCID), Wiskott Aldrich syndrome, and multiple myeloma**. Bone marrow transplant includes peripheral blood bone marrow stem cell harvesting and transplantation following high-dose chemotherapy.
- **Non-human Organ transplants, except for porcine (pig) heart valve, are not covered**.
- **All transplants must meet Medical Necessity criteria** as determined by your TPA and it must be Certified.
- All Organ transplants must be deemed Medically Necessary by the Participant's Provider/Practitioner. **Transplant services shall be performed at a site approved by your TPA**.
- **Limited travel benefits** are available for the transplant recipient 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 in- and out-of-state, up to a **maximum of $150 per day for the transplant recipient and companion combined**. **All benefits for transportation, lodging and meals are limited to a lifetime maximum of $10,000**. **Travel reimbursements must be submitted within 12 months from the travel. This benefit does not include transportation costs for deceased Participants**,

except as outlined in the *Covered Services* Section under Repatriation Reimbursement.

- If there is a living donor that requires Surgery to make an Organ available for a covered transplant for a Participant, coverage is available for expenses incurred by the donor for travel, surgery, laboratory and X-ray services, organ storage expenses, and Inpatient follow-up care only. Your TPA will pay the Total Allowable Charges for a donor who is not entitled to benefits under any other health benefit plan or policy.
- **Transplant services obtained from Out-of-Network Providers/Practitioners are not covered**.

Virtual Visits/Telehealth

This Medical Program covers virtual visits with your contracted provider based on the type of service. (i.e., Primary Care Provider (PCP) cost share, Specialist cost share, or Urgent Care cost share).

Video Visits are covered through the National Carrier 24/7 for Members, refer to your SOB for cost share amounts.

Weight Management Programs

This Medical Program covers weight loss or other weight management programs, dietary control or medical obesity treatment if dietary advice and exercise are provided by a provider, nutritionist or dietician licensed by the appropriate agency and the service is **preauthorized** by Presbyterian Health Plan. The member must have a body mass index (BMI) of 40 or more (BMI is calculated as the patient's weight in kilograms divided by the patient's height in meters quartered). See Surgery and Related Services for information about surgery for weight loss purposes. This Medical Program does not cover nonmedical services such as Weight Watchers, Jenny Craig Personal Weight Management, gym, fitness club or spa programs.

Women's Healthcare

The following services are available for female Participants age 13 or over.

Obstetrical/Gynecological Care includes annual exams, care related to pregnancy, miscarriage, therapeutic abortions, elective abortions up to 24 weeks and other obstetrical/gynecological services.

Women's Preventive Care including but not limited to the following:

- Well-Woman Visits.
- Mammography.

- Gestational diabetes screening.
- HPV DNA testing.
- Sexually transmitted infections (STI) counseling.
- Human immunodeficiency virus (HIV) Screening and Counseling.
- Contraception and contraceptive counseling.
- Food and Drug Administration (FDA) approved women's surgical sterilization procedures.
- Contraception implant insertion/reinsertion.
- Breastfeeding support, supplies, and counseling.
- Interpersonal and domestic violence screening and counseling.

Maternity and Newborn Care

Newborns' and Mothers' Health Protection Act of 1996 Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your provider, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

- **Maternity Coverage** is available to a mother and her newborn child (if enrolled); under this PBB for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. Hospital admissions must be Certified if in excess of this provision.

  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 Participant's attending Provider/Practitioner. In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her Attending Provider/Practitioner. 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 Participants or other support person(s) will be available to the mother for the first few days following early discharge.

  Postpartum care in the home is covered in accordance with accepted maternal and neonatal Provider/Practitioner assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided

by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

Coverage for postpartum care in the home includes a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending provider or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending provider or person with appropriate licensure, training and experience to provide postpartum care.

- **Newborns of a Participant or a Participant's spouse** will be covered from the moment of birth when enrolled as follows:
  - **The newborn must be enrolled within 60 calendar days from the date of birth**.
  - If enrollment of a newborn results in an increase to the amount of payment due, the applicable payment must be paid.

  If conditions listed above are not met, the newborn cannot be enrolled for coverage until the next annual open enrollment period.
- Neonatal care is available for the newborn of a Participant 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, the newborn stay must be Certified.
- Benefits for enrolled newborns shall include coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, and where necessary to protect the life of the infant, transportation, including air transport to the nearest available tertiary facility. Enrolled newborn benefits also include newborn visits in the Hospital by the baby's Provider/Practitioner, circumcision, incubator, and routine Hospital nursery charges. **Circumcisions performed other than during the newborn's Hospital stay are only covered when Medically Necessary**.

High-Risk Ambulance Services in accordance with the *Covered Services* Section under "Ambulance Services."

Midwives/Midwifery is the provision of women's healthcare management in the antepartum, intrapartum, postpartum, and interconceptual periods and infants up to six weeks of age.

The services of a Licensed Midwife or Certified Nurse Midwife are covered, **subject to the following limitations**:

- The Midwife's services must be provided under the supervision of a licensed obstetrician or licensed family Provider/Practitioner.

- The services must be provided in preparation for or in connection with the delivery of a newborn infant.
- 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 Participant or Provider/Practitioner to occur in the home.
- The combined fees of the midwife and any attending or supervising Provider/Practitioner(s), for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Provider/Practitioner had they been the sole Provider/Practitioner of those services.
- **The services of a lay Midwife or an unlicensed Midwife are not covered**.

Prenatal Maternity Care

Benefits which include prenatal care, pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test for women, generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus), visits to an Obstetrician, certified nurse-midwife, or Licensed Midwife, Medically Necessary nutritional supplements as determined by the attending Provider/Practitioner, childbirth in a hospital or in a licensed birthing center. Please see Schedule of Benefits for special copay information. **Elective Home Births are not covered**.

Elective Abortions are covered when performed prior to the 24th week of pregnancy.

Cytologic Screening (Pap Smear), Human Papillomavirus (HPV) Screenings, HPV Vaccine Coverage for females 9 to 14 years of age and other populations ***in accordance with guidelines established by*** The Advisory Committee on Immunizations Practices (ACIP), and mammography coverage described in the *Covered Services* Section under “Cytologic Screening (Pap smear screening) and Human Papillomavirus screening” and “HPV Vaccine Coverage.”

Mastectomy, Prosthetic Devices and Reconstructive Surgery

Women’s Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending provider and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other Covered Services provided under this Plan.

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 the attending provider and patient 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 the Deductible, Copay and Coinsurance** consistent with those imposed on other benefits.

Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). 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. Two bras per year are covered for Participant's with external breast prosthesis. **All care must be provided by or under the direction of the Participant's Provider/Practitioner and with appropriate Benefit Certification/Prior Authorization from the Participant's TPA**.

Osteoporosis Coverage

For services related to the diagnosis, treatment, and appropriate management of **osteoporosis when such services are determined to be Medically Necessary** by the Participant's Provider/Practitioner in consultation with the Participant's TPA.

LIMITATIONS AND EXCLUSIONS

Please read this Section carefully. It identifies the limitations that apply to certain Covered Services and specifies the Healthcare Services and Supplies that are **not covered** under this Plan.

NOTE:
If you disagree with your TPA's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of your TPA's decision. See "Appeals and Grievance Procedures" in the *Filing Claims* Section.

Limitations

The following benefits have limits applied:

- **Acupuncture Treatment** benefits are limited to an Annual Plan Year maximum of 40 visits per Participant for covered expenses combined with Chiropractic services.
- **Air Ambulance** charges for non-emergencies will be covered only if Medically Necessary.
- **Benefit Certification/Prior Authorization** is availability of certain services and supplies are subject to Benefit Certification/Prior Authorization as specified in the *How the Plan Works* Section under "Benefit Certification/Prior Authorization."
- **Benefit Limitations**. Some services may be subject to dollar amount and/or visit limitations or may not be available from Out-of-Network Provider/Practitioners. Refer to your *Schedule of Benefits* and the *Covered Services* Section for these limitations. **All services are subject to the requirements identified in the *Covered Services* Section**, **the Benefit Certification/Prior Authorization requirements listed in the *How the Plan Works* Section**, **the plan limitations listed in this Section and the exclusions listed in the *Exclusions* Section)**.
- **Chiropractic Services** are limited to an Annual Plan Year of 40 visits per Participant for covered expenses combined with Acupuncture services.
- **Cochlear Implants** and related care are limited to implantation of a hearing device to facilitate communication for the profoundly hearing impaired, including any necessary training required to use the device.
- **Consumable Medical Supplies** are covered during hospitalization. They are also covered during an office visit or authorized home health visit. This Plan does **not cover** supplies used at other times by the Participant or Participant's family. Consumable medical supplies are (1) usually disposable, (2) cannot be used repeatedly by more than one individual, (3) are primarily used for a medical purpose, (4) generally are useful only to a person who is ill or injured and (5) are ordered or prescribed by a licensed Provider/Practitioner.

LIMITATIONS AND EXCLUSIONS

- **Contact Lenses or Eyeglasses** are limited to services necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or prescribed by a provider as the only treatment available for keratoconus. Duplicate lenses are **not covered**, and replacement is covered only if a provider or optometrist recommends a change in prescription due to the medical condition.
- **Dental Services** covers only those procedures listed as Covered Services as indicated in the *Covered Services* Section under "Dental Services."
- **Diagnostic Testing for Infertility** is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and your TPA determines that the recommended treatment is **not covered**, no further testing will be covered under this Plan.
- **Durable Medical Equipment, Orthotic and Prosthetic Devices and External Prostheses** require **Benefit Certification/Prior Authorization**. Discuss the need for Benefit Certification/Prior Authorization with your Provider/Practitioner.
- **Family Planning** coverage is limited to Depo-Provera injections, diaphragms, implantable contraceptive devices (insertion and removal), intrauterine devices (IUDs), genetic testing, and sterilization procedures.
- **Home Healthcare** services require **Benefit Certification/Prior Authorization**. Discuss the need for Benefit Certification/Prior Authorization with your Provider/Practitioner.
- **Hospice Care** benefits are limited to patients who are terminally ill as described in the *Covered Services* Section. **Benefit Certification/Prior Authorization** is required. Discuss the need for Benefit Certification/Prior Authorization with your Provider/Practitioner.
- **Infertility Testing** is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the treatment is determined **not covered** by this Plan, no further testing will be covered under this Plan.
- **Infertility Treatment** is limited to Surgery to open obstructed tubes, epididymis or vasectomy when not the result of sterilization and replacement of deficient hormones if there is documented evidence of a deficiency.
- **Major Disasters**. In the event of any Major Disaster, epidemic or other circumstances beyond your TPA's control, your TPA shall render or attempt to arrange Covered Services with In-Network Providers/Practitioners insofar as practical, according to its 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 your TPA's control, and if your TPA has 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 war, act(s) of terrorism, riot, civil insurrection, and disability of a

significant part of a Hospital, your TPA personnel or In-Network Providers/Practitioners or similar causes. This provision does not impose any limitation on the availability of coverage for services provided by Out-of-Network Providers/Practitioners.

- **Organ Transplants** are limited to those procedures and benefits described in the *Covered Services* Section under "Transplants."
- **Physical, Occupational and Speech Therapy** are limited to 70 visits combined per Participant per Annual Plan Year.
- **Reconstructive** Surgery requires **Benefit Certification/Prior Authorization**, or no benefits are payable through the Plan.
- **Repairs or Replacement of Non-Rental Durable Medical Equipment**, **Orthotics and Prosthetic Devices** when Medically Necessary due to wear and damage requires **Benefit Certification/Prior Authorization** or no benefits are payable under this Plan.
- **Routine Eye Screenings** are limited to Dependents through age 17.
- **Routine Hearing Screenings** Hearing exam for evaluation to determine hearing loss and need of hearing aids.
- **Skilled-Nursing Care** is limited to 60 days per Annual Plan Year and is subject to **Benefit Certification/Prior Authorization**. Discuss the need for **Benefit Certification/Prior Authorization** with your Provider/Practitioner.
- **Transplants Benefits** for travel, lodging, and meals are limited to an adult transplant recipient and one other person, including travel cost that may be required for transplant evaluation. For minor children, benefits are payable for two adults. Lodging and meals are limited to $150 per day combined, including the transplant patient, to a maximum lifetime benefit payment of $10,000, to including transportation. Donor organ procurement costs for the surgical removal, storage, and transportation of the donated organ are covered for Reasonable and Customary Charges.

LIMITATIONS AND EXCLUSIONS

Exclusions

Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice. This includes any service, which is not generally recognized by the medical community as conforming to accepted medical practice or any service for which the required approval of a government agency has not been granted at the time the service is provided.

Activities of Daily Living are not a Covered Service, including assistance in bathing, dressing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter.

Adoption/Surrogate Expenses are not a Covered Service.

Alternative/Complementary Therapies, except as specified in the *Covered Services* Section under "Complementary Therapies" of this *PBB*.

Ambulance (including air ambulance) charges which are not Medically Necessary.

Amniocentesis and/or Ultrasound to determine the gender of a fetus are **not Covered Service**s under this Plan.

Any Condition, disability, or expense sustained as a result of being engaged in an illegal occupation, commission or attempted commission of an assault or other illegal act, participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

Artificial Aids including speech synthesis devices (except items identified as being covered in the *Covered Services* Section under "Durable Medical Equipment" of this PBB).

Artificial Conception including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as artificial insemination, in-vitro ("test tube") or in-vivo fertilization, GIFT, ZIFT, all drugs, hormonal manipulation, donor sperm or embryo transfer are **not Covered Services**. Any Artificial Conception method not specifically listed is also excluded.

Athletic Trainers are **not covered** under this Plan.

Autism/Applied Behavioral Analysis:

- Any experimental, long-term, or maintenance treatments.
- Services that are not Medically Necessary.
- Any services received under the federal Individuals with Disabilities Education Improvement Act of 2004.

- Related state laws that place responsibility on state and local school boards for providing specialized education and related services to children who have Autism Spectrum Disorder.
- Respite services or care.
- Services in accordance with a treatment plan that has not been Certified by your TPA.
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT).
- Music therapy, vision therapy, or touch or massage therapy.
- Floor time.
- Facilitated communication.
- Elimination diets, nutritional supplements, intravenous immune globulin infusion, secretin infusion.
- Chelation therapy.
- Hippotherapy, animal therapy, or art therapy.

Autopsies and/or Transportation Costs for deceased Participants, except as outlined in the *Covered Services* Section under "Repatriation Reimbursement."

Baby Food (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.

Before Effective Date, **Benefits Are Not Available** for that portion of any Inpatient treatment provided before the Participant's coverage effective date or for any service or supply received before the Participant's effective date under this Plan.

Behavioral Health Services are not a Covered Service under this Plan unless associated with a manifest behavioral/mental health disorder.

Behavioral Health Services:

- **Halfway Houses**.
- **Co-dependency Treatment**.
- **Counseling**: sex, pastoral/spiritual, and bereavement counseling.
- **Psychological Testing** when not Medically Necessary.
- **Special Education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. 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 *Covered Services* Section under "Family, Infant and Toddler (FIT) Program."

Benefits and Services Not Specified as Covered Services.

LIMITATIONS AND EXCLUSIONS

Bereavement Counseling is not a Covered Service under this Plan.

Biofeedback

Blood charges if the blood has been replaced and blood donor storage fees if when there is not a scheduled procedure.

Care for conditions which state or local law requires be treated in a public or correctional facility.

Care for Military Service connected disabilities to which the Participant is legally entitled and for which facilities are reasonably available to the Participant.

Charges that are determined to be unreasonable by your TPA and charges in excess of Reasonable and Customary Charges.

Circumcisions performed other than during the newborn's hospital stay, unless Medically Necessary.

Clinic or Other Facility Services that the Participant is eligible to have provided without charge.

Clothing or Other Protective Devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not.

Common Disposable Medical Supplies that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze (such as four by fours), and Ace bandages, except when provided in a Hospital or Provider/Practitioner's office or by a home health professional.

Complications of Non-Covered Services, supplies and treatment received including, but not limited to, complications for non-covered transplants, cosmetic, Experimental or Investigational procedures, sterilization reversal, infertility treatment, or non-covered gender reassignment services are **not Covered Services**, unless authorized by the Plan.

Contact Lenses or Eyeglasses unless specifically listed as a Covered Service under this Plan.

Convalescent Care or rest cures.

Convenience Items: 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/jacuzzies, 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).

Corrective Eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, except as identified in the *Covered Services* Section under "Durable Medical Equipment" of this PBB.

Cosmetic Surgery including but not limited to breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except when used for truncal veins), and nasal rhinoplasty.

Cosmetic Treatments, devices, orthotics, and medications.

Counseling Services unless listed as a Covered Service.

Court-ordered Evaluation or Treatment, or treatment that is a condition of parole or probation or **in lieu of sentencing**, such as Alcohol or Substance Use programs and/or psychiatric evaluation or therapy.

Custodial Care such as sitters, homemaker's services, or care in a place that serves the patient primarily as a residence when the Participant does not require skilled nursing care.

Dental Services:

- **Dental care** and dental X-rays, except as provided in the *Covered Services* Section under "Dental Services/TMJ/CMJ" hospitalization, day surgery, Outpatient services and/or anesthesia for non-Covered dental services **are covered if provided in a hospital or ambulatory surgical center for dental surgery when approved by your TPA**.
- **Malocclusion Treatment**, if part of routine dental care and orthodontics.
- **Orthodontic Appliances and Orthodontic Treatment (Braces)**, crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.

Diagnostic Testing for infertility is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the treatment is determined to be not covered by this Plan, no further testing will be covered under this Plan.

Diagnostic, **Therapeutic**, **Rehabilitative or Health Maintenance Services** provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider/Practitioner.

Domiciliary Care or care provided in a residential institution, treatment center, halfway house, or school because a Participant's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Donor Expenses incurred by a Participant are not a Covered Service under this Plan, except as specified in this PBB.

Duplicate Coverage including, but not limited to:

- Services already covered by other valid coverage.
- Services already paid under Medicare or that would have been paid if the Participant was entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. If the Participant's prior coverage has an extension of benefits provision, this Plan will not cover charges incurred after the Participant's effective date under this Plan that are covered under the prior plan's extension of benefits provision.

Duplicate Diagnostic Tests or over reads of laboratory, pathology, or radiology tests are **not covered**.

Durable Medical Equipment:

- **Duplicate Durable Medical Equipment** items (i.e., for home and office). **Duplicate equipment** is not covered under this Plan for Participant convenience, comfort or travel purposes. Members who are employed outside the home for two or more hours on a given day shall be eligible for an additional or alternative oxygen system, as medically appropriate, as determined by your TPA.
- **Functional Foot Orthotics** including those for plantar fasciitis, pes planus (flat feet), heel spurs and other conditions (as determined by your TPA), Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom-fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Upgraded or Deluxe Durable Medical Equipment**.
- **Additional Wheelchairs**, if the Participant has a functional wheelchair, regardless of the original purchaser of the wheelchair.
- **Repair or Replacement Of Durable Medical Equipment**, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience.
- **Repair and Replacement** of items under the manufacturer or supplier's warranty.

Educational or Institutional Services except for diabetes education and preventive care provided under routine services as described in the *Covered Services* Section.

Elastic Support Hose.

Elective Abortions after the 24th week of pregnancy.

Elective Home Birth and any prenatal or postpartum services connected with an Elective Home Birth. Allowable sites for a delivery of a newborn are Hospitals and licensed birthing centers. Elective Home Birth means a birth that was planned or intended by the Participant or Provider/Practitioner to occur in the home.

Emergency Facilities for non-emergent services are not Covered Services.

Environmental Control expenses are not Covered Services under this Plan.

Exercise Equipment, videos, personal trainers, club membership and weight reduction programs are not Covered Services under this Plan.

Experimental or Investigational or Unproven Drugs, **Medicines**, **Procedures**, **Devices**, **and/or Other Services as Determined by Your TPA On Behalf of The Plan**. This means that one or more of the following is true:

- The independent assessment organization used by your TPA, has rated the treatment, procedure or device as being a “C” or “D,” which indicates unproven benefit (unless your TPA has otherwise determined that coverage should be provided based on their assessment).
- The drug, medicine or device cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), approval marketing has not been given at the time the drug, medicine, or device is furnished, or the FDA has determined that use of the drug, medicine or device is contraindicated for the particular indication for which it has been prescribed.
- Reliable evidence shows that the drug, medicine, and/or device, treatment, or procedure is the subject of ongoing Clinical Trials (under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis), except as specified in the *Covered Services* Section under Clinical Trials.
- Reliable evidence shows that the consensus of opinion among experts (such as the FDA) 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.
- Reliable evidence means only published reports and articles in authoritative peer reviewed medical and scientific literature. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure or device; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment,

procedure or device. Reliable evidence does not include the results of coverage determinations from other healthcare insurers.

- An Experimental or Investigational or unproven drug, medicine, treatment, procedure, or device will not be covered solely due to the fact that it is the only treatment available for a specific medical condition.

Extracorporeal Shock Wave Therapy involving the musculoskeletal system is **not covered** under this Plan.

Eye Exercises and Refractions are not Covered Services under this Plan.

Food and Lodging Expenses are not covered except for those that are eligible for per diem coverage under the "Transplant Services" provision in the *Covered Services* Section.

Foot Care including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone Surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails, unless medical conditions such as diabetes exist.

Genetic Inborn Errors of Metabolism:

- Food substitutes for lactose intolerance including soy foods or formulas or other Over-the-Counter digestive aids.
- Organic foods.
- Ordinary foodstuffs that might be part of an exclusionary diet.
- Food substitutes that do not qualify as Special Medical Foods.
- Any product that does not require a Provider/Practitioner's prescription.
- Special Medical Foods for conditions that are not present at birth.
- Food items purchased at a health food, vitamin or similar store.
- Foods purchased on the Internet.
- Special Medical Foods for conditions including, but not limited to diabetes mellitus, hypertension, hyperlipidemia, obesity and allergies to food products.

Gloves, unless part of a wound treatment kit.

Hair-loss (or Baldness) treatments, medications, supplies and devices, including wigs, and special brushes.

Healthcare that is associated with an injury which is obtained or associated in the commission of a crime.

Home Healthcare Services for care that:

- Is provided primarily for the convenience of the Participant or the Participant's family.
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter.
- Is provided by a nurse who ordinarily resides in the Participant's home or is a member of the Participant's immediate family.

Hospice Care benefits are **not covered** for the following services:

- Food, housing, and delivered meals.
- Volunteer services.
- 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).
- Homemaker and housekeeping services.
- Private duty nursing.
- Pastoral and spiritual counseling.
- Bereavement counseling.
- Respite Care.

Human Chorionic Gonadotrophin (HCG) injections are not a Covered Service under this Plan.

Hypnotherapy or services related to hypnosis, whether for medical or anesthetic purposes, except as covered in the *Covered Services* Section under "Smoking Cessation Treatment."

Implantation of artificial organs or mechanical devices, except as specified in this booklet, are not a Covered Service under this Plan unless as a result of illness or injury, and **Benefit Certification/Prior Authorization** is obtained from your TPA prior to services being provided.

Infertility Testing and Treatment unless specifically listed as a Covered Service. Also, see "Artificial Conception" under the *Exclusion* Section of this booklet.

Late Claims Filing: This Plan does not cover services submitted for benefit determination if your TPA receives the claim **more than 12 months** after the date of service.

Note: If there is a change in the Claims Administrator, the length of this timely filing period may also change.

LIMITATIONS AND EXCLUSIONS

Lay Midwife or unlicensed Midwife Services are **not covered** under this Plan.

Learning Disabilities and Behavioral Problems: This Plan does not cover special education, counseling, therapy, or care for learning or behavioral problems.

Legal Payment Obligations: Services for which the Participant has no legal obligation to pay or that are free, charges made only because benefits are available under this Plan, services for which the Participant has received; a professional or courtesy discount, services provided by the Participant upon oneself or a covered family Participant, by one ordinarily residing in the Participant's household, by a family member, or Provider/Practitioner charges exceeding the amount specified by the Health and Human Services Department when benefits are payable under Medicare.

Local Anesthesia charges that have been included in the cost of the surgical procedure are **not covered**.

Long-Term Rehabilitation Services are **not covered**. 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**.

Maintenance or Long-term Therapy or care or any treatment (Inpatient or Outpatient) that does not significantly improve the Participant's function or productivity, or care provided after the Participant have reached his/her rehabilitative potential (unless therapy is Covered during an approved Hospice Benefit Period) is **not covered** under this Plan. In a dispute about whether the Participant's rehabilitative potential has been reached, he/she is responsible for furnishing documentation from his/her Provider/Practitioner supporting his/her opinion that his/her rehabilitative potential has not been reached.

Note: Even if the Participant's rehabilitative potential has not yet been reached, this Plan does not cover services that are in excess of maximum benefit limitations.

Massage Therapy is **not covered** under this Plan, except when performed by a Licensed Physical Therapist under the Physical Therapy benefit.

Medical Equipment to include, but not be limited to, stethoscopes and blood pressure monitors unless listed as a covered item under this Plan.

Medically Unnecessary Services: This Plan does not cover services that are not Medically Necessary as defined in the *Covered Services* Section, unless such services are specifically listed as covered (e.g., see "Preventive Services").

Membership Fees are not a Covered Service under this Plan.

Non-Human Organ Transplants except for porcine (pig) heart valve.

Non-Medical Equipment is **not a Covered Service** under this Plan.

LIMITATIONS AND EXCLUSIONS

Non-Medical Expenses: This Plan does not cover non-medical expenses (even if medically recommended and regardless of therapeutic value), including charges for services such as but not limited to missed appointments, “get-acquainted” visits without physical assessment or Medical Care, the provision of medical information to perform pre-admission or concurrent review, filling out of claim forms, mailing and/or shipping and handling charges, interest expenses, copies of medical records, modifications to home, vehicle, or workplace to accommodate medical conditions, voice synthesizers, other communication devices, Membership fees at spas, health clubs, or other such facilities even if medically recommended.

Nonprescription and Over-the-Counter drugs are excluded.

Nonstandard or Deluxe Equipment is **not a Covered Service** under this Plan.

Nutritional Supplements are **not a Covered Service** under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a Covered Service.

Organ Transplant Donor medical and/or hospital services when the recipient of an Organ Transplant is not a Participant or when the transplant procedure is not covered.

Orthodontic Appliances and Treatment, Crowns, Bridges, Or Dentures for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders unless the disorder is trauma related. Also, nonstandard diagnostic, therapeutic and surgical treatments of TMJ are not Covered Services under any circumstances.

Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for Participants with diabetes or other significant neuropathies.

Orthoptics are **not a Covered Service** under this Plan.

Personal Convenience items such as air conditioners, humidifiers, or physical fitness exercise equipment, or **personal services** such as haircuts, shampoos and sets, guest meals, and radio or television rentals are **not covered**.

Personal Trainers are **not covered** under the provisions of this Plan.

Photopheresis for all conditions other than mycosis fungoides.

Physical Examinations, **Vaccinations, Drugs and Immunizations** for the primary intent of medical research or non-Medically Necessary purposes(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment, and/or immunizations.

Post-Termination Care: Except as otherwise required by applicable law this Plan does not cover services received after your coverage is terminated, even if **Benefit**

Certification/Prior Authorization for such services were needed because of an event that occurred while you were covered.

Prescription Drugs contact CVS Caremark at 1-877-745-4394.

Private-Duty Nursing charges are **not covered** under this Plan unless services are considered Medically Necessary.

Private Room Expenses are **not a Covered Service** under this Plan unless there is documented medical necessity.

Protective Clothing or Devices are **not covered** under this Plan.

Radial Keratotomy, **LASIK** and other eye refractive surgeries are **not Covered Services** under this Plan.

Respite Care is excluded.

Reversals of Voluntary Sterilization are not covered**.**

Rolfing is **not a Covered Service** under this Plan.

Routine Foot Care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses, unless Medically Necessary due to diabetes or other significant neuropathies.

Self-Help Programs and Therapies not specifically covered in this booklet, such as behavior modification, music, art, dance, recreation and Z therapy, massage therapy except when performed by a Licensed Physical Therapist, a Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

Services rendered to a Participant for treatment from injuries sustained in the commission of a crime are not covered.

Services for which the Participant or Dependent is eligible under any governmental program (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Participant or Dependent.

Services not specifically identified as a benefit in this booklet, or services not listed as a Covered Service in this booklet.

Services Requiring Benefit Certification/Prior Authorization when Benefit Certification/Prior Authorization was not obtained. Participants are not liable when an In-Network Provider/Practitioner does not obtain Benefit Certification/Prior Authorization.

LIMITATIONS AND EXCLUSIONS

Sexual Dysfunction treatment, including medication, counseling, and clinics, except for penile prosthesis as listed in the *Covered Services* Section under "Durable Medical Equipment" of this PBB.

Speech Therapy charges not otherwise listed as a Covered Service under this Plan.

Standby Professional Services are **not covered** under this Plan.

Storage or Banking of sperm, ova (human eggs), embryos, zygotes or other human tissue.

Surgical Sterilization Reversal of voluntary infertility procedures is **not covered** under this Plan.

Thermography (a technique that photographically represents the surface temperatures of the body) is **not covered** under this Plan.

Transplants not specifically listed as a Covered Service under this Plan are **not covered**.

Transportation Costs for deceased Participants, except as outlined in the *Covered Services* Section under "Repatriation Reimbursement" of this PBB.

Travel and Lodging Expenses except as provided in the *Covered Services* Section under "Transplants" of this *PBB.*

Travel and Other Transportation Expenses, except as covered under "Ambulance Services" and "Medical Evacuation" are **not covered**.

Unreasonable Charges will not be covered by this Plan.

Untimely Filing: Claims filed **more than 12 months after the date of service** are **not covered**.

Veterans Administration Facility Services or supplies furnished by a Veterans Administration facility for a service-connected disability, or while a Participant is in active military service are **not covered**.

Vision Services:

- **Eye Movement Therapy except as listed in the Participant Benefit Booklet for rehabilitation services related to post physical brain injury**.
- **Eye Refractive Procedures** including radial keratotomy, laser procedures, and other techniques.

- **Routine Vision Care and Eye Refractions** for determining prescriptions for corrective lenses, except as identified in the *Covered Services* Section under "Durable Medical Equipment" and "Clinical Preventive Services" of this PBB.
- **Visual Training**.

Vitamins, dietary/nutritional supplements, special foods, formulas, or diets are not covered under this Plan.

Vocational Rehabilitation Services and Long-term Rehabilitation are **not covered** under this Plan.

Weight-Loss Programs are not a Covered Service under this Plan. (Unless for medically necessary treatment for morbid obesity).

Work-Related Conditions, injuries, occupational illness or disease, if the Participant is required to be covered under Workers' Compensation Insurance, whether or not such coverage actually exists.

FILING CLAIMS

As a Participant of this Plan, for payment to be made you will generally **not** have claims to file or papers to fill out for medical services obtained from In-Network Providers/Practitioners. In-Network Providers/Practitioners will bill your TPA directly.

On occasion you may access care from a non-contracted provider such as in an emergency when you are traveling outside of the service area. In such cases you may have to file a claim yourself.

Emergency Services Or Out-Of-Network Providers/Practitioners

In some cases, Hospital, laboratory, X-ray, and clinic claims are filed by the Out-of-Network Providers/Practitioners, as well as In-Network. Out-of-Network Provider/Practitioners may also file claims for you.

You will be required to submit claim forms when you're Out-of-Network Provider/Practitioner does not file them for you. Please submit all claims when the services are received and attach the itemized bill for those services or supplies. Do not file for the same service twice unless requested by your TPA's Customer Service Center Representative.

The Member Claim Forms are available from your TPA's Customer Service Center Representative. They can also be printed out from your TPA's website. Please mail the claim forms and itemized bills to your TPA's claim address on the back of your ID card.

Claims must be submitted no later than 12 months after the date a service or supply was received. If your Provider/Practitioner does not file a claim for you, you are responsible for filing the claim within the 12-month deadline. **Claims submitted after the 12-month deadline are not eligible for benefit payments**. If a claim is returned for further information, you must resubmit it within 90 days.

Out-of-Network Service Claims

When you obtain Covered Services from an Out-of-Network Provider/Practitioner, the Provider/Practitioner, hospital, or you should file the claims with your TPA. If the Provider/Practitioner or hospital does not file the claims, ask for an itemized statement and complete it the same way that you would for services received from an Out-of-Network Provider/Practitioner. Payments for these services may be required to be made by **you**.

Claims Outside the United States

Benefits are available for emergent and urgent services received outside the United States. These services are covered as explained in the *Covered Services* Section of this *PBB*. **Participants are responsible for ensuring that claims are appropriately translated and that the monetary exchange is clearly identified when submitting claims for services received outside the United States**.

FILING CLAIMS

Itemized Bills

Itemized bills must be submitted on billing forms or letterhead stationery and must show:

- Name and address of the Provider/Practitioner or other healthcare Provider/Practitioner.
- Full name of the patient receiving treatment or services.
- Date, type of service, diagnosis, and charge for each service separately.

The only acceptable bills are those from healthcare Provider/Practitioners. Canceled checks, balance due statements, cash register receipts or bills you prepare yourself are not acceptable. Please make a copy of all itemized bills for your records before you send them because the bills are not returned to you. Itemized bills are necessary for your claim to be processed so that all benefits available under this Plan are provided.

If your itemized bill(s) include services previously filed, identify clearly the new charges that you are submitting.

Prescription Drug Claims

Claims for Prescription Drugs must be sent to the pharmacy benefit manager. Please call **CVS Caremark** at **1-877-745-4394** for the claims filing procedures for Prescription Drugs.

How Payments are Made

Payments to Out-of-Network Provider/Practitioners are sent to the Participant unless the Participant has assigned benefits to the Provider/Practitioner. When possible, this Plan will honor an Assignment of Benefits; however, your TPA reserves the right to pay the Participant directly and to refuse to honor an Assignment of Benefits to pay anyone other than the Participant in any circumstances.

Provider/Practitioner payments are based on In-Network Provider/Practitioner agreements and the Negotiated Fee Schedule as determined by your TPA. You are responsible for paying all Copays, Coinsurance, and non-Covered Services.

If you obtain services from an Out-of-Network Provider/Practitioner, you are responsible for any amounts greater than Reasonable and Customary amounts. You are also responsible for paying all Copays, Deductibles, Coinsurance, and non-Covered Services.

Payment of benefits for Participants eligible for Medicaid is made to the New Mexico Human Services Department or to the Medicaid Provider when required by law.

Additional information may be requested to process your claim, coordinate benefits, or protect the subrogation interest. You must supply the information or agree to have the information released by another person to your TPA.

You may be requested to have another Provider/Practitioner examine you if there are questions about a **Benefit Certification/Prior Authorization** review or about a particular service or supply for which you are claiming benefits. In this event, the Plan will cover the requested examination.

If you obtain services from an In-Network Provider/Practitioner in New Mexico, they will request Benefit Certification/Prior Authorizations from your TPA, when required. If you obtain services from a National Network Provider outside New Mexico or Out-of-Network Provider, then it is your responsibility to obtain Benefit Certification/Prior Authorization, when required. If you fail to obtain Benefit Certification/Prior Authorization when required, service will not be covered.

Overpayments

If payments made by your TPA are greater than the benefits you have under this Plan, you are required to refund the excess. In the event that you do not, future benefits may be withheld and applied to the amount that you owe to your TPA.

Coordination of Benefits

If a Participant is also covered under any other health benefit plan, other public or private Employer programs, or any other health insurance policy, the benefits provided or payable hereunder shall be reduced to the extent that benefits are available to the Participant under such other plan, policy or program whether or not a claim is made for the same.

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

- **Employee/Dependent Rule**.
  - The plan, which covers the Participant as an employee pays first.
  - The plan, which covers the Participant as a Dependent, pays second.
- **Birthday Rule for Dependent children of parents not separated or divorced**.
  - The plan, which covers the parent whose birthday falls earlier in the year, pays first. The plan, which covers the parent whose birthday falls later in the year, pays second. The birthday order is determined by the month and the day of birth, not the year of birth.

- If both parents have the same month and day of birth, the plan that covered the parent longer, will pay claims first. The plan, which covered the parent for a shorter period of time, pays second.

- **Dependent children of separated or divorced parents**.
  - The plan of the parent decreed by a court of law to have responsibility for medical coverage pays first.
  - In the absence of a court order:
    - ❖ The plan of the parent with physical custody of the child pays first.
    - ❖ The plan of the spouse of the parent with physical custody (i.e., the stepparent) pays second.
    - ❖ The plan of the parent not having physical custody of the child pays third.
- **Active/Inactive**.
  - The plan, which covers the Participant as an active employee (or Dependent of an active employee), pays first.
  - The plan, which covers the Participant as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.

- **Longer/Shorter**.

  In the case of a Participant who is the contract holder under more than one Employer health insurance policy, then the plan that has covered the Participant for a longer period of time will pay first. The start of a new plan does not include a change of insurance carrier by the employer.

- **No Coordination Provision**. In spite of rules listed above the plan that has no provision regarding coordination of benefits will pay first.

- **If a Participant is covered under a motor vehicle or homeowners insurance policy** which provides benefits for medical expenses resulting from a motor vehicle accident or accident in the Participant's own home, the Participant shall not be entitled to benefits under this Plan for injuries arising out of such accident to the extent they are covered by their motor vehicle or homeowner's insurance policy. If such benefits have been provided by you, your TPA shall have the right to recover any benefits provided from the motor vehicle or homeowner's insurer or the Participant to the extent they are available under the motor vehicle or homeowner's insurance policy.

- In no event shall the 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, your TPA**:
  - May release, request, or obtain claim information from any individual or organization. In addition, any Participant claiming benefits shall furnish your TPA with any information which it may require.

  - Has the right, if overpayment is made by your TPA because of the Participant's 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.
  - Will not be obligated to pay for non-Covered Services or Covered Services not obtained in compliance with your TPA's policies and procedures.
- **Participants who are on COBRA Continuation** and are covered by another Employer plan shall receive benefits to the extent that this Plan is secondary payor of all eligible charges, subject to the terms, conditions and limitations of this Plan.

Medicare

The benefits under this Plan for Participants enrolled in Medicare are not designed to duplicate any benefit to which the Participant is entitled under the Social Security Act. Benefits will be coordinated in compliance with current applicable federal regulations.

Medicaid

Benefits payable by this Plan on behalf of an Enrollee 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 Enrollee 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 Provider/Practitioner.

Subrogation (Recovering Healthcare Expenses from Others)

The benefits under this Plan will be available to a Participant who is injured by the act or omission of another person, firm, operation or entity. If a Participant receives benefits under this Plan for treatment of such injuries, your Plan will be subrogated to the rights of the Participant or the Personal Representative of a deceased Participant, or Dependent Participant, to the extent of all such payments made by your Plan for such benefits. This means that if your Plan provides or pays benefits, you must repay the Plan the amounts recovered in any lawsuit, settlement, or by any other means. This rule applies to any and all monies a Participant 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, your Plan’s right of subrogation includes, but is not limited to, the right to be repaid when a Participant recovers money for personal injury sustained in a car accident. The subrogation right applies whether the Participant recovers directly from the wrongdoer or from the wrongdoer’s insurer, or from the Participant’s uninsured motorist insurance coverage. The Participant agrees to sign and deliver to the TPA, on

behalf of the Plan, such documents and papers as may be necessary to protect the Plan's subrogation right. The Participant also agrees to keep the TPA advised of:

- Any claims or lawsuits made against any person, firm or entity responsible for any injuries for which the Plan has paid 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 your TPA, on the Plan's behalf, is a violation of this Plan. In the event a Participant fails to cooperate with the TPA or takes any action, through agents or otherwise, to interfere with the exercise of the Plan's subrogation right, the Plan may recover its benefit payments from that Participant.

When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both the Participant and the Plan, the Plan will, upon request by the Participant or the Participant's attorney, share such collection costs and legal expenses, in a manner that is fair and equitable, but only if the plan receives appropriate documentation of such collection costs and legal expenses.

Appeals and Grievances

Appeals

Your TPA will administer Level I and Level II appeals on behalf of the Plan 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 Service, and/or rescission of coverage in the event of fraud or intentional misrepresentation of material fact. (**Note**: your TPA 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 Appeals and Grievance section of the PBB include the Employee and/or covered Dependent(s)) must submit a request for an appeal to the TPA within 180 days of receipt of a notice of denial of items or services under the Plan. The Participant must tell the TPA the reason why the denial should be overturned and include any information supporting the appeal. The TPA will acknowledge to the Participant in writing within one working day that it has received a request for an Appeal. The acknowledgement letter will contain the name, address, and direct telephone number of an individual at the TPA who may be contacted regarding the appeal.

- Time frames 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 **15 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 **40 calendar days**. The TPA may extend the review period for a maximum of **10 calendar days** for pre-service requests and **20 calendar days** for post-service requests if the TPA can:

1) Show reasonable cause beyond the TPA's control for the delay.
2) Show that the delay will not result in increased medical risk to the Participant.
3) Provide a written progress report to the Participant and the related provider within the 25-day or 60-day review period. Participants must agree, in writing, to a request to extend a deadline.

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 provider 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. The TPA will not conduct expedited appeals for services already provided ("post service") to a Participant. If a Participant requests an expedited decision, the TPA 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 the TPA, 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, the TPA will notify the applicable Participant and then process the appeal within **15 calendar days**.

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

  The appeal will be reviewed by the TPA 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 TPA 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, the TPA will approve coverage of the services. The applicable Participant and the applicable provider will be notified by mail or electronic means (i.e., fax, email, etc.) within **two calendar 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 telephone within 24 hours that the adverse determination has been upheld and by written or electronic means within one working day of the telephone notification. Written notification must be provided in a linguistically appropriate manner. 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, the TPA will mail to the participant written notification of the decision and confirmation of the Participant's decision not to pursue the appeal within **three calendar days** of the Medical Director's decision.

If the TPA is unable to contact the Participant by telephone within 72 hours after making the decision to uphold the initial adverse determination, then the TPA 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 calendar days**, the TPA will again try to contact the Participant by telephone. If the Participant does not respond to the TPA's telephone calls and does not return the response letter within **20 calendar days** of the written notification to uphold the initial decision, the TPA 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 the TPA 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 time frames 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 the TPA will conduct the appeal on behalf of 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 the TPA staff and one (1) or more healthcare or other professionals. At least one (1) 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 the TPA. Panel members must be present physically or by video or telephone conferencing to hear the appeal. A panel member who is not present to hear the appeal either physically or by video or telephone conferencing will not participate in the decision.

- Notice of Internal Panel Review Hearing:

  The TPA 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 the TPA, asking questions of the healthcare professionals on the internal panel review committee, and 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 the TPA prior to the hearing. Failure to notify may require rescheduling of the hearing within the time frame allowed to complete the appeal. If the TPA 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. The TPA will notify the Participant of this at least **three calendar days** before the hearing.

  The TPA will accept a Participant's reasonable request for postponement of a hearing. Time frames previously described for completing an appeal will be extended during the period of any postponement.

- Time frames for Internal Panel Review Committee:

  No fewer than **three calendar days** prior to the internal panel review, the TPA will provide the participant with pertinent records, the 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 the TPA, and 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 Laws as related to Appeals is defined as the regulations issued in the July 23, 2010 Federal Register, June 24, 2011 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 provider 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 the time frames previously noted. The TPA will notify the participant and the treating provider of the internal panel review committee's decision by telephone within 24 hours of making a decision, and in writing or by electronic means within one working day of the telephone 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:

  - The 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.
  - 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 Independent Review Organization (IRO). Review by an IRO is voluntary and explained in the next section. The Participant must receive the written notice in a linguistically appropriate manner.

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 Independent Review Organization (IRO) as defined by Applicable Law. An IRO is an independent review organization, external to the Employer and the TPA that utilizes independent providers with appropriate expertise to perform external reviews of appeals. 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.

When an appeal is denied by the TPA, 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:

- 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 the TPA and receive a denial of appeal before requesting an external review of an appeal with an IRO.

- After a Participant receives a denial of an appeal, the Participant must submit the request for external review of appeal with the TPA 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.
- The TPA 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.
- Within five days after receipt of the request for external review, the TPA 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 TPA 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.
- 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 investigative 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 linguistically appropriate manner. 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.

- 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 the TPA waives any right to assert that the Participant failed to exhaust administrative remedies.

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, and 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, the TPA will send the Participant written acknowledgement of the grievance within **three calendar days** after receipt. The letter will contain the name, address, and direct telephone number of a TPA representative who may be contacted regarding the administrative grievance. The review of the grievance will be conducted by a TPA representative authorized to take action related to the grievance, if applicable, and will allow the Participant to provide to the TPA any information relevant to the grievance.

The TPA will mail a written response to the Participant within **15 calendar days** of receipt of the grievance. The TPA may extend the 15-day time frame when there is a delay in obtaining documents or records necessary for the review of a grievance, provided that the TPA notifies the Participant in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the Participant and the TPA.

The TPA’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 calendar 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, the TPA will appoint a reconsideration committee consisting of TPA 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, the TPA will schedule and hold a hearing within **15 calendar days**. 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 the TPA's expense. The TPA will not unreasonably deny a request for postponement of the hearing.

- Reconsideration Committee Hearing:

  The TPA will notify the Participant in writing of the hearing date, time, and place of the reconsideration committee hearing at least **10 calendar days** in advance. The notice will advise the Participant of his or her rights to attend the hearing, present a case to the committee, submit supporting material both before and at the hearing, ask questions of any representative of the TPA, and be assisted or represented by a person of the Participant's choice that may or may not be a legal representation. If the TPA 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 his or her 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 time frame allowed for administrative grievances. No fewer than **three calendar days** prior to the hearing, the TPA 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

  The TPA will mail a written decision to the Participant within **seven calendar 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 review by the Employer.

GLOSSARY OF TERMS

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.

Admission means the period of time between the date a patient enters a Hospital or other facility as an Inpatient and the date he/she is discharged as an Inpatient. The date of Admission is the date of service for the hospitalization and all related services.

Alcoholism means alcohol dependence or alcohol use disorder meeting the criteria as stated in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-5) for these disorders.

Ambulance Service means a duly licensed transportation service, capable of providing Medically Necessary life support care in the event of a life-threatening emergency situation.

Ambulatory Surgical Center means an appropriately licensed Provider/Practitioner, with an organized staff of Provider/Practitioners that meets all of the following criteria:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
- Provides treatment by or under the supervision of Provider/Practitioners and nursing services whenever the patient is in the facility.
- Does not provide Inpatient accommodations.
- Is not a facility used primarily as an office or clinic for the private practice of a Provider/Practitioner or other professional Provider/Practitioner.

Annual Plan Year means the period beginning July 1 and ending June 30 of the following year.

Annual Plan Year Out-Of-Pocket Maximum means a specified dollar amount of Covered Services received in an Annual Plan Year that is the Participant's responsibility.

Appeal means a request from a Participant or their representative, or a Provider/Practitioner for reconsideration of an adverse determination (denial, reduction, suspension or termination of a benefit).

Application means the form that an employee is required to complete when enrolling for coverage.

Attending Provider/Practitioner means the doctor who is responsible for the patient's Hospital treatment or who is charged with the patient's overall care and who is responsible for directing the treatment program. A consulting Provider/Practitioner is not the Attending Provider/Practitioner. A Provider/Practitioner employed by the Hospital is not ordinarily the Attending Provider/Practitioner.

GLOSSARY OF TERMS

Balance Billed is when the Provider/Practitioner bills the Participant for the difference between what the Provider/Practitioner billed and what the Plan Paid.

Behavioral Health Disorder means any disorder, other than a disorder induced by alcohol or drug use that impairs the behavior, emotional reaction, or thought process of a person, regardless of medical origin.

Behavioral Health Services means the services that are required to treat a disorder that impairs, the behavior, emotional reaction, or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the physiological symptoms related to Behavioral Health Disorder are not considered to be charges made for the treatments of a Behavioral Health Disorder.

Benefit Certification/Prior Authorization/Certified means the process whereby the TPA or TPA's delegated Provider/Practitioner contractor reviews and approves, in advance, the provision of certain Covered Services to Participants before those services are rendered. If a required Benefit Certification/Prior Authorization is not obtained for services rendered by an Out-of-Network Provider/Practitioner (Tier 3), the Participant may be responsible for the resulting charges. Services rendered beyond the scope of the **Benefit Certification/Prior Authorization** may not be covered.

Birthing Center means an alternative birthing facility licensed under state law, with care primarily provided by a Certified Nurse Midwife.

Cardiac Rehabilitation means the improvement of functions having to do with the heart.

Certified Nurse-Midwife means a licensed Registered Nurse, certified by the American College of Nurse Midwives to administer Maternity care within the scope of the license.

Certificate of Creditable Coverage means a Certificate given to a Participant when his/her enrollment from the Plan terminates and which states the period of time that the Participant was covered by the TPA under a benefit plan for healthcare services. Either the Participant's Employer or TPA may be responsible to prepare and deliver the Certificate, in compliance with all applicable requirements of state and federal law, to the Participant.

Cessation Counseling means a program, including individual, Employer or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides counseling at a minimum on establishment of reasons 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 materials and method for verifying Enrollee 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.

Chiropractor means a person who is a Doctor of Chiropractic, licensed by the appropriate governmental agency to practice chiropractic medicine.

Clinical Trial means 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 other life-threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation 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 one of the entities described in (a) through (d) above.

(f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants.

(g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be 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.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Co-Dependency means behaviors learned by family Participants or significant others in order to survive in an environment of great emotional pain and stress when a family Participant is dependent upon the use of alcohol or drugs.

Coinsurance means the amount, expressed as a percentage, of a covered healthcare expense that is partially paid by the Plan and partially the Participant's responsibility to pay. The cost-sharing responsibility ends for most Covered Services in a particular Annual Plan Year when the Out-of-Pocket Maximum has been reached.

Complaint means the first time a TPA is made aware of an issue of dissatisfaction, not complex in nature. For more complex issues of dissatisfaction see definition for Grievance.

GLOSSARY OF TERMS

Congenital Anomaly means any condition from birth significantly different from the common form, for example, a cleft palate or certain heart defects.

Copay means the amount, expressed as a fixed-dollar figure, required to be paid by a Participant in connection with Healthcare Services. Benefits payable by the Plan are reduced by the amount of the required Copay for the Covered Service.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Covered Services means services or supplies specified in this PBB, subject to the terms, conditions, limitations, and exclusions of this PBB.

Craniomandibular (CMJ) means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

Custom-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.

Custodial or Domiciliary Care means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's 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 and a pelvic exam for symptomatic as well as asymptomatic female patients.

Deductible means the amount that must be paid for by you each Annual Plan Year toward Covered Services **before** health benefits for that Participant will be paid by the Plan (except for those services requiring only a Copay).

Dentist means a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMA) who is licensed to practice prevention, diagnosis, and treatment of diseases, accidental Injuries, and malformation of the teeth, mouth, and jaws.

Dependent means any Participant of a covered employee’s family who meets the requirements of the *Eligibility, Enrollment, Effective and Termination Dates* Section of this PBB and is actually enrolled in the Plan.

Diagnostic Services means procedures ordered by a Provider/Practitioner or other professional Provider/Practitioner to determine a definite condition or disease.

GLOSSARY OF TERMS

Durable Medical Equipment means equipment prescribed by a Provider/Practitioner that is Medically Necessary for the treatment of an illness or Accidental Injury, or to prevent the patient's further deterioration. This equipment is designed for repeated use, generally not useful in the absence of illness or Accidental Injury, and includes items such as oxygen or oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

Elective Home Birth means a birth that was planned or intended by the Participant or Provider/Practitioner to occur in the home.

Emergency Health Services means healthcare procedures, treatments, or services delivered to a Covered person 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.

Enrollee means anyone who is entitled to receive healthcare benefits provided by the Plan.

Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to your health, if pregnant the health of you or your unborn infant; 2) serious impairment to the bodily functions; or 3) serious dysfunction of any bodily organ or part.

Evidence-Based Medical Literature means only published reports and articles in authoritative, peer-reviewed medical and scientific literature.

Experimental/Investigational means any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and **not** Experimental or Investigational, treatment **must meet all five** of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies.
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the Investigational settings.

GLOSSARY OF TERMS

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.

Family Coverage means coverage for the employee, the employee's spouse/domestic partner, and the employee's Dependent children.

Family, Infant and Toddler (Fit) Program means an early intervention services program provided through the Family Infant, and Toddler program to eligible children and their families in accordance with requirements under Senate Bill 589 as defined in Title 7, Chapter 30, Part 8 Health Family & Children Healthcare Services.

FDA means the United States Food and Drug Administration.

Freestanding Dialysis Facility means a Provider primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home basis.

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.

Grievance means an oral or written complaint submitted by or on behalf of a Participant regarding the:

- Availability, delivery or quality of Healthcare Services.
- Administrative practices of the healthcare insurer that affect the availability, delivery or quality of Healthcare Services.
- Claims payment, handling or reimbursement for Healthcare Services.
- Matters pertaining to any aspect of the health benefits Plan.

Healthcare Professional means a Provider/Practitioner or other healthcare provider, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Healthcare Services consistent with state law.

Healthcare Services means services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, and includes, to the extent offered by the health benefits plan, physical and Behavioral Health, including community-based Behavioral Health.

GLOSSARY OF TERMS

Hearing Aids means Durable Medical Equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

Home Health Agency means an appropriately licensed provider that both:

- Brings skilled nursing and other services on an intermittent, visiting basis into the Participant's home in accordance with the licensing regulations for home health agencies in New Mexico or in the locality where the services are administered.
- Is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the Attending provider.

Hospice means a duly licensed facility or program, which has entered into an Agreement with a Participant's TPA to provide healthcare services to Participants who are diagnosed as terminally ill.

Hospital means an acute care general Hospital, that:

- Provides Inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed Provider/Practitioners.
- Is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.
- Is duly licensed to operate as an acute care general Hospital under applicable state or local law.

Human Papillomavirus (HPV) means a test approved by the Federal Food and Drug Administration for detection of the Human Papillomavirus.

Identification Card or **ID Card** means the card issued to the covered employee enrolled under this Plan.

Immunosuppressive Drugs (Inpatient only) means drugs used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include but are not limited to:

1) Preventing transplant rejection.
2) Supplementing chemotherapy.
3) Treating certain diseases of the immune system (i.e., "auto-immune" diseases).
4) Reducing inflammation.
5) Relieving certain symptoms.
6) Other times when it may be helpful to suppress the human immune response.

Independent Clinical Laboratory means a laboratory that performs clinical procedures under the supervision of a Provider/Practitioner and that is not affiliated or associated with a Hospital, Provider/Practitioner, or other Provider.

GLOSSARY OF TERMS

In-Network Provider/Practitioner means Provider/Practitioners, Hospitals, and other Healthcare Professionals, facilities, and suppliers that have contracted with a Participant's TPA as In-Network Provider/Practitioners.

Inpatient means a Participant who has been admitted by a healthcare Provider/Practitioner to a Hospital for occupancy for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute-care services rendered to Participants, who are registered bed patients for which there is a room and board charge, and which are covered as defined in this Plan. Admissions are considered Inpatient based on Medical Necessity as identified in the Participant's TPA designated level of care criteria, regardless of the length of time spent in the Hospital.

Licensed Acupuncturist means an Acupuncture practitioner who is licensed by the appropriate state authority. Certification alone does not meet the licensure requirement.

Licensed Midwife means a person who has successfully completed all the requirements for New Mexico Licensed Midwifery and is in good standing with the Public Health Division. Licensed Midwives must follow midwifery protocols in accord and with the "*Standards and Core Competencies of Practice for Licensed Midwives in New Mexico*" and the "*New Mexico Midwives Association: - Practice Guidelines*."

Licensed Practical Nurse (LPN) means a nurse who has graduated from a formal, practical nursing education program and is licensed by the appropriate state authority.

Lifetime Maximum Benefit means the maximum dollar amount the Plan will pay for a particular benefit during the lifetime of a Participant.

Long-Term Therapy or Rehabilitation Services Therapies are considered Long-term if the Participant's Provider/Practitioner, in consultation with the Participant's TPA, does not believe Significant Improvement is likely to occur within two months. Long-term therapy includes but is not limited to treatment of chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Chronic conditions include, but are not limited to, muscular dystrophy, Down syndrome and cerebral palsy.

Maintenance Therapy means treatment that does not significantly enhance or increase the patient's function or productivity.

Malocclusion means abnormal growth of the teeth causing improper and imperfect matching.

Maternity means any condition that is pregnancy related. Maternity care includes prenatal and postnatal care, and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion, or cesarean section.

Medicaid means Title XIX and/or XXI of the Social Security Act and all amendments thereto.

Medical Care means professional services administered by a Provider/Practitioner or another professional Provider for the treatment of an illness or Accidental Injury.

GLOSSARY OF TERMS

Medically Necessary means appropriate or necessary services as determined by a Provider/Practitioner in consultation with the Participant's TPA. These services are provided to a Participant for any Covered condition requiring, according to generally accepted principles of good medical 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 TPA consistent with such federal, national and professional practice guidelines, for the diagnosis or direct care and treatment of an illness, injury, or medical condition, and are not services provided only as a convenience.

Medicare means the program of healthcare for the aged, end-stage renal disease (ESRD) beneficiaries, and disabled, established by Title XVIII of the Social Security Act and all amendments thereto.

Medicare Supplemental Coverage means healthcare coverage that provides supplemental benefits to Medicare coverage.

National PPO Provider means a Provider/Practitioner, including medical facility, with which the Participant's TPA has arranged a discount for services(s) provided out-of-state (outside of New Mexico).

Negotiated Fee Schedule means the contracted amount that a TPA agrees to pay to PCPs and In-Network Provider/Practitioners for Hospital, professional services, and other charges, and for which PCPs and In-Network Provider/Practitioners agree to accept as payment for services rendered to Participants.

Non-Participating Provider/Practitioner means a healthcare Provider/Practitioner, including medical facilities, who has not entered into an agreement with a TPA to provide healthcare services to Participants.

Nutritional Support means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is only covered when enteral tube feedings are required.

Observation means those furnished by a Hospital and Provider/Practitioner 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 as an Inpatient, 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 Provider's/Practitioner's written order. If not formally admitted as an Inpatient, the patient initially is treated as an Outpatient. The Participant must meet the TPA's designed level of care criteria to be considered an Inpatient admission. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

Obstetrician/Gynecologist means a Provider/Practitioner who is board eligible or board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

Occupational Therapist means a person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction, caused by disease,

trauma, Congenital Anomaly, or prior therapeutic process, through the use of specific tasks or goals directed activities designed to improve functional performance of the patient.

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.

Other Provider means a person or facility other than a Hospital that is licensed in the state where services are rendered, to administer Covered Services. Other Providers include:

- An institution or entity only listed as:
    - Ambulance Provider
    - Ambulatory Surgical Facility
    - Birthing Center
    - Durable Medical Equipment Supplier
    - Freestanding Dialysis Facility
    - Home Health Agency
    - Hospice Agency
    - Independent Clinical Laboratory
    - Pharmacy
    - Rehabilitation Hospital
    - Urgent Care Facility
- A person or practitioner only listed as:
    - Certified Nurse Midwife
    - Certified Registered Nurse Anesthetist
    - Chiropractor
    - Dentist
    - Licensed Acupuncturist
    - Licensed Practical Nurse
    - Occupational Therapist
    - Physical Therapist
    - Podiatrist
    - Licensed Lay Midwife
    - Registered Nurse
    - Respiratory Therapist
    - Speech Therapist

Out-Of-Network Provider/Practitioner means a duly licensed healthcare Provider/Practitioner, including a medical facility, which has no agreement with the Participant's TPA for reimbursement of services.

GLOSSARY OF TERMS

Out-Of-Network Services means services obtained from an Out-of-Network Provider/Practitioner as defined above.

Outpatient means care received in a Hospital department, Ambulatory Surgical Facility, Urgent Care facility, or Provider/Practitioner's office where the patient leaves the same day.

Participant means the eligible employee or Dependent that is enrolled under this Plan.

Participant Benefit Booklet (PBB) means this booklet.

Participating Provider means any duly licensed Practitioner of the healing arts acting within the scope of his/her license who has entered into an agreement directly with a TPA to provide healthcare services to the TPA's Plan Participants.

Participating In-Network Provider/Practitioner means any duly licensed individual or institutional Provider of healthcare services which has entered into an agreement directly with a TPA to provide healthcare services to the TPA's Plan Participants.

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.

Photopheresis means the use of photosensitizing chemicals and special therapy to treat the blood of patients with certain cancers of the skin. The blood circulates through a computerized pheresis unit which destroys the abnormal cells in the body as they circulate from the skin to the blood.

Physical Therapist means a licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body. A Physical Therapist treats disease or Accidental Injury by physical and mechanical means.

Provider/Practitioner means a duly licensed practitioner of the healing arts acting within the scope of his/her license.

Podiatrist means a licensed Doctor of Podiatric Medicine (DPM). A Podiatrist treats conditions of the feet.

PPO means Preferred Provider Organization.

Prefabricated Orthosis means an Orthosis which is manufactured in quantity without a specific patient in mind. Prefabricated Orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). An Orthosis that is assembled from Prefabricated components is considered Prefabricated. Any Orthosis that does not meet the definition of a Custom-Fabricated Orthosis is considered Prefabricated.

Prescription Drugs means those drugs that, by Federal law, require a Provider/Practitioner's prescription for purchase: **Administered by CVS Caremark, call 1-877-745-4394**.

Preventive Services means office visits where services rendered are preventive, not diagnostic.

Prosthesis, Prosthetic Device means an externally attached or surgically implanted artificial substitute for an absent body part, for example, an artificial eye or limb.

Provider means a duly licensed Hospital, Provider/Practitioner, or other Provider performing within the scope of the appropriate licensure.

Pulmonary Rehabilitation means a program of therapy designed to improve lung functions.

Reasonable Charge or Reasonable and Customary (R&C) Charge means the amount determined to be payable by a TPA for services rendered to Participants by Out-of-Network Provider/Practitioners (Tier 3), based upon the following criteria:

- Fees that a professional Provider/Practitioner usually charges for a given service.
- Fees which fall within the range of usual charges for a given service filed by most professional Provider/Practitioners in the same locality who have similar training and experience.
- Fees which are usual and customary, or which could not be considered excessive in a particular case because of unusual circumstances.

Reconstructive Surgery means the following:

- Surgery to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery 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 Midwife means a person licensed by the state to provide Healthcare Services in pregnancy and childbirth within the scope of New Mexico Lay Midwifery Regulations.

Registered Nurse (RN) means a nurse who has graduated from a formal program of nursing education diploma school, associate degree, or baccalaureate program and is licensed by appropriate state authority.

Rehabilitation Hospital means an appropriately licensed facility that, for compensation from its patients, provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Provider/Practitioners. Continuous nursing services are provided under the supervision of a Registered Nurse.

Repatriation Reimbursement means the reimbursement of expenses in connection with the transportation of the body of a deceased covered Participant. See *Covered Services* Section under "*Repatriation Reimbursement*" for full explanation of benefit.

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.

GLOSSARY OF TERMS

Respiratory Therapist means a person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

Screening Mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic persons 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.

Semi-Private means a two or more bed Hospital room, Skilled Nursing Facility or other healthcare facility or program.

Short-Term Rehabilitation means rehabilitation and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected within two months from the date therapy first begins.

Significant Improvement means that the patient is likely to meet all therapy goals for the first two months of therapy, or the patient has met all therapy goals in the preceding two months of therapy, as specifically documented in the therapy record.

Skilled-Nursing Care means services that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse or Registered Nurse.

Skilled-Nursing Facility means an institution that is licensed under state law to provide Skilled Nursing Care services.

Smoking Cessation Counseling/Program means a program, including individual, Employer, 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, and distribution plan for patient education material and method for verifying Enrollee 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 participation rates and impact of the program.

Special Care Unit means a designated unit that has concentrated all facilities, equipment, and supportive devices for the provision of an intensive level of care for critically ill patients.

Specialist means a Doctor of Medicine (MD) or Doctor of Osteopathy (DO). A Specialist is not a family practitioner, general practitioner, pediatrician, or internist.

Special Medical Foods means nutritional substances in any form that are:

- Formulated to be consumed or administered internally under the supervision of a Provider/Practitioner and prescribed by a Provider/Practitioner.
- Specifically processed or formulated to be distinct in one or more nutrients present in natural food.
- Intended for the medical and nutritional management of Participants with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation.
- Essential to optimize growth, health and metabolic homeostasis.

Speech Therapist means a speech pathologist certified by the American Speech and Hearing Association. A Speech Therapist assists patients in overcoming speech disorders.

Student means a person attending an accredited college or university, trade or secondary school.

Subluxation (Chiropractic) means misalignment, demonstrable by X-ray or chiropractic examination, which produces pain and is correctable by manual manipulation.

Surgery/Surgical means the performance of generally accepted operative and cutting procedures, including Specialized instrumentation, endoscopic examinations, and other invasive procedures; Correction of fractures and dislocations; and Usual and related preoperative and postoperative care.

Substance Use Disorder means dependence or Use of substances meeting the criteria as stated in *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-5) for these disorders.

TEFRA means Federal law regarding the working aged.

Temporomandibular Joint (TMJ) is the joint that hinges the lower jaw (mandible) to the temporal bone of the skull.

Terminally Ill Patient means a Participant with a life expectancy of six months or less as certified in writing by the Attending Provider/Practitioner.

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, cuttas, 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 Providers/Practitioners, the Total Allowable Charges may not exceed the amount the In-Network Provider/Practitioner has agreed to accept from the Participant's TPA for a Covered Service and for Out-of-Network Providers/Practitioners, the Total Allowable Charges may not exceed the **Reasonable and Customary Charge** as determined by the Participant's TPA for a service.

Two-Party Coverage means coverage for the employee and his/her spouse, or coverage for the employee and Dependent Children.

UNM is the University of New Mexico.

Urgent Care means Medically Necessary healthcare services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

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.

Urgent Illness means an unexpected illness that is non-life-threatening that requires prompt medical attention. Some examples of urgent situations are sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, fever, small lacerations, minor burns, severe stomach pain, swollen glands, rashes, poisoning and back pain.

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 through the age of 72 months, 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 Provider means any Provider/Practitioner who specializes in women's health and is recognized as a Women's Healthcare Provider by the Participant's TPA.