# City of Rio Rancho
# Point-of-Service (POS) Benefit Plans

## Summary Plan Description

Offered by City of Rio Rancho

Administered by Presbyterian Health Plan, Inc.

Copay Medical Plan

HWG20000

City of Rio Rancho POS
MPC062485 07/01/2024

## Welcome

This Summary Plan Description (SPD) describes your group medical benefits. City of Rio Rancho offers this Point-of-Service (POS) Plan, hereafter referred to as the "Plan" or "Agreement."

This SPD is intended to provide you with easy-to-understand general explanations of the more significant provisions of your Plan effective July 1, 2023. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this SPD and the Claims administrative procedures of our Third-Party Claim Administrator, Presbyterian Health Plan, or if any provision is not covered or only partially covered, the terms of this SPD will govern in all cases.

This SPD does not imply a contract of employment. City of Rio Rancho reserves the right to terminate, discontinue, alter, modify, or change this Plan/Agreement or any provision of this Plan/Agreement at any time.

It is your responsibility to read and understand the terms and conditions in this SPD. You are urged to read this SPD carefully and use it to make well-informed benefits decisions for you and your family.

# Important Phone Numbers and Addresses

## Presbyterian Customer Service Center

**Address:**
Presbyterian Health Plan
Attention: Presbyterian Customer Service Center
P.O. Box 27489
Albuquerque, NM 87125-7489

**Phone:**
(505) 923-5208 or
1-877-752-4164
TTY: 711 or 1-877-298-7407

## Prior Authorization

**Address:**
Presbyterian Health Plan
Attention: Health Services Department
P.O. Box 27489
Albuquerque, NM 87125-7489

**Phone:**
(505) 923-5208 or
1-877-752-4164

## Claims

**Address:**
Presbyterian Health Plan
Attention: Claims Department
P.O. Box 27489
Albuquerque, NM 87125-7489

**Phone:**
(505) 923-5208 or
1-877-4164

## Appeals and Grievances

**Address:**
Presbyterian Health Plan
Attention: Grievance Department
P.O. Box 27489
Albuquerque, NM 87125-7489

**Phone:**
(505) 923-5208 or
1-877-752-4164

OR

**Address:**
Office of Superintendent of Insurance
Managed Healthcare Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689

**Phone:**
1-855-427-5674
**Fax:**
(505) 827-4253

## Website

www.phs.org

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# Summary of Benefits

*The following are the Highlights of the City of Rio Rancho Point of Service (POS) Copay Plan administered by Presbyterian Health Plan, Inc., (PHP) for City of Rio Rancho employees. These benefits are effective 7/1/23 through 06/31/24. The specific terms of coverage, limitations and exclusions are detailed in Sections 2, 4, and 5 of the Summary Plan Description.*

| **CITY of RIO RANCHO – Copay Plan (HWG20000) BENEFITS AND COVERAGE** | **In-network Limits** | **Out-of-network Limits** |
|---|---|---|
| **ANNUAL CALENDAR YEAR DEDUCTIBLE -** Customary Charges and additional charges incurred as a result of failure to obtain Prior Authorization are not counted towards the Deductible. There is no cross accumulation between In- and Out-of-network services. | None | Individual: $300<br>Double: $600<br>Family: $900 |
| **ANNUAL OUT-OF-POCKET MAXIMUM -** Includes Annual Calendar Year Deductible Copayments and Coinsurance only – Does not include penalty amounts, charges above Reasonable and Customary, or non-Covered charges, including charges incurred after the benefit maximum has been reached. There is no cross accumulation between In- and Out-of-network services. | Individual: $1,000<br>Double: $2,000<br>Family: $3,000 | Individual: $3,500<br>Double: $7,000<br>Family: $10,500 |
| **BENEFITS AND COVERAGE** | **In-network Copayment/Coinsurance** | **Out-of-network Coinsurance** |
| **PROVIDER SERVICES** including: | | |
| Office Visits | | |
| • Primary Care Provider (PCP) | $20 Copay per visit - Adult<br>$10 Copay per visit – Child | 30% Coinsurance |
| • Specialist | $40 Copayment per visit | 30% Coinsurance |
| • Video Visits | $0 Copayment | 30% Coinsurance |
| Home visits if Medically Necessary | $40 Copayment per visit | 30% Coinsurance |
| Outpatient surgery (in Provider's office) | Included in office visit Copay | 30% Coinsurance |
| Medical Drugs [(1)] (injectable forms administered in Provider's office) | 15% Coinsurance | 30% Coinsurance |
| Allergy services | | |
| • Testing | 20% Coinsurance | 30% Coinsurance |
| • Serum (extracts) | 20% Coinsurance | 30% Coinsurance |
| • Injections | Included in office visit Copay (waived if nursing visit only) | 30% Coinsurance |
| Injections such as insulin, heparin and injectable antibiotics | Included in office visit Copay (waived if nursing visit only) | 30% Coinsurance |

***[(1)] Prior Authorization may be required. [(2)] Not subject to Deductible. [(3)] You are responsible for any balance due above Reasonable and Customary Charges. [(4)] 20 percent penalty applies if Prior Authorization is not obtained.***

***(5) Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.***

| CITY of RIO RANCHO – Copay Plan (HWG20000) | In-network Copayment/Coinsurance | Out-of-network Coinsurance |
|---|---|---|
| **PROVIDER SERVICES** (continued from previous page)<br>**Preventive Services**<br>• Routine physicals<br>• Well-child care including vision and hearing screening (through age 26)<br>• Immunizations<br>• Adult Wellness<br>• Health education programs | Covered at 100% | 30% Coinsurance |
| Women's Preventive Services<br>• Contraceptive Methods<br>• Intrauterine Devices (IUD)<br>• Hormone Contraceptive Injections<br>• Inserted Contraceptive Devices<br>• Implanted Contraceptive Devices | Covered at 100% | 30% Coinsurance |
| **Breastfeeding support, supplies and counseling (for one year after delivery)** | | |
| Some infertility services including drugs and injections. (1) See your SPD for full details. | | |
| On-campus Student Health Center | $20 Copayment per visit - Adult<br>$10 Copayment per visit - Child | 30% Coinsurance |
| Hospital and Skilled Nursing Care visits | $0 Copayment | 30% Coinsurance |
| **HOSPITAL SERVICES** – Inpatient (1)<br>Coverage includes:<br>• Room and Board<br>• Newborn delivery and other Hospital Obstetrical services<br>• In-Hospital Provider visits, Surgeons, Anesthesiologist and other Inpatient services<br>• Detoxification<br>• Newborn care if discharged and re-admitted | $500 Copayment per admission | 30% Coinsurance (4) |

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# SUMMARY OF BENEFITS

| CITY of RIO RANCHO – Copay Plan (HWG20000)<br>BENEFITS AND COVERAGE | In-network<br>Copayment/Coinsurance | Out-of-network<br>Coinsurance |
|---|---|---|
| **MEDICAL SERVICES** – Outpatient | | |
| • Surgeries [1] (at facility) | $250 Copayment | 30% Coinsurance [4] |
| • Bariatric surgery [1], when Medically Necessary | $250 Copayment | Not Covered |
| • X-ray and laboratory tests | $0 Copayment | 30% Coinsurance |
| • PET [1]/CAT [1]/MRI [1] scans | $100 Copayment per test per day | 30% Coinsurance [4] |
| • Cardiac Cath/ GI lab | 15% Coinsurance to a maximum of $300 per visit | 30% Coinsurance |
| • Radiation therapy (non-surgical) | $0 Copayment | 30% Coinsurance |
| • Chemotherapy | $0 Copayment | 30% Coinsurance |
| Medical Drugs [1] Oral or inhalation forms/ self-administered | 15% Coinsurance | 30% Coinsurance |
| Medical Drugs [1]<br>Intravenous (IV) | 15% Coinsurance | 30% Coinsurance |
| • Sleep studies | | |
| ○ Home | $50 Copayment per study | 30% Coinsurance |
| ○ Outpatient | $50 Copayment per study | 30% Coinsurance |
| • Administration of blood/blood components | $0 Copayment | 30% Coinsurance |
| **RECONSTRUCTIVE SURGERY [1]** | Included in Hospital services - Inpatient<br>Medical services - Outpatient and Provider services | 30% Coinsurance |
| **EMERGENCY ROOM CARE**<br>Including trauma services | $100 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies) | $100[2] Copayment for the initial visit. (waived if admitted into a Hospital, then Hospital Copayment applies). Follow up care will be subject to deductible and 30% Coinsurance |
| **URGENT CARE** | $40 Copayment per visit | $40 Copayment per visit |

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***(5) Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.***

| CITY of RIO RANCHO – Copay Plan (HWG20000)<br>BENEFITS AND COVERAGE | In-network Copayment/Coinsurance | Out-of-network Coinsurance |
|---|---|---|
| **AMBULANCE SERVICES** including:<br>Emergency or high-risk | | |
| • Ground ambulance | $50 Copayment per occurrence | $50 Copayment per occurrence(2) |
| • Air ambulance | $100 Copayment per occurrence | $100 Copayment per occurrence(2).<br>Member will be responsible for any balance due above Reasonable and Customary charges. |
| Inter-facility transfer Services | | |
| • Ground ambulance | No Charge | No Charge |
| • Air ambulance | No Charge | No Charge<br>Member will be responsible for any balance due above Reasonable and Customary charges. |
| **WOMEN'S HEALTHCARE** | | |
| Gynecological care | $20 Copayment per visit – Adult<br>$10 Copayment per visit - Child | 30% Coinsurance |
| In office Obstetrical/Maternity Care/ Prenatal and Postnatal care | $20 Copayment per visit up to a maximum of $200 per pregnancy | 30% Coinsurance |
| Specialist (i.e., Perinatologist) | $40 Copayment per visit<br>Not included in $200 maximum listed above | 30% Coinsurance |
| Cytologic (Pap smear), Human Papillomavirus (HPV) screening, and Mammograms refer to Clinical Preventive Services | | |
| Newborn Delivery and other Hospital Obstetrical services | $500 Copayment per admission | 30% Coinsurance |
| Implantable contraceptive devices | | |
| • Insertion | Included in office visit Copayment | 30% Coinsurance |
| • Removal | Included in office visit Copayment | 30% Coinsurance |

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# SUMMARY OF BENEFITS

| CITY of RIO RANCHO – Copay Plan (HWG20000)<br>BENEFITS AND COVERAGE | In-network<br>Copayment/Coinsurance | Out-of-network<br>Coinsurance |
|---|---|---|
| **DIABETES SERVICES**<br>Office visit and diabetes education | $20 Copayment | 30% Coinsurance |
| Diabetic supplies or External Prosthetic Appliances [(1)] (Purchased through a Durable Medical Equipment supplier) | 30% Coinsurance | 50% Coinsurance[(4)] |
| **COVERED MEDICATIONS**<br>Medical Drugs [(1)] Oral or inhalation forms/self-administered | 15% Coinsurance | 30% Coinsurance |
| Medical Drugs [(1)] Intravenous (IV) | 15% Coinsurance | 30% Coinsurance |
| **PRESCRIPTION DRUGS** | **Administered by Express Scripts**.<br>Call Express Scripts at **1-866-217-3774** | |
| **MENTAL HEALTH SERVICES [(1)]**<br>Outpatient | $20 Copay per visit - Adult<br>$10 Copay per visit – Child | 30% Coinsurance |
| Inpatient | $500 Copayment per admission | 30% Coinsurance [(4)] |
| Partial Hospitalization | $500 Copayment per admission | 30% Coinsurance [(4)] |
| **ALCOHOL AND SUBSTANCE USE SERVICES [(1)]**<br>Detoxification | | |
| • Outpatient | $20 Copay per visit - Adult<br>$10 Copay per visit – Child | 30% Coinsurance [(4)] |
| • Inpatient | $500 Copayment per admission | 30% Coinsurance [(4)] |
| Rehabilitation –<br>• Outpatient | $40 Copayment per visit | 30% Coinsurance [(4)] |
| • Inpatient/Partial Hospitalization | $500 Copayment per admission | 30% Coinsurance [(4)] |

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| CITY of RIO RANCHO – Copay Plan (HWG20000)<br>BENEFITS AND COVERAGE | In-network<br>Copayment/Coinsurance | Out-of-network<br>Coinsurance |
|---|---|---|
| **REHABILITATION AND THERAPY SERVICES**<br>Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year) (copayment for Office Visit only - one copayment per day) | $20 Copayment per visit – Adult<br>$10 Copayment per visit – Child | **Not Covered** |
| Dialysis/Plasmapheresis/Photopheresis | 20% Coinsurance per visit | 30% Coinsurance |
| Pulmonary Rehabilitation<br>(up to 24 sessions per Calendar Year)<br>(copayment for the Office Visit only - one copayment per day) | $20 Copayment per visit – Adult<br>$10 Copayment per visit – Child | **Not Covered** |
| **SHORT-TERM REHABILITATION**[1]<br>Physical therapy | | |
| • Inpatient | $500 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Hospice, or Skilled Nursing Facility) | 30% Coinsurance [4] |
| • Outpatient (up to 80 visits per Calendar Year if Medically Necessary)[5] | $40 Copayment per visit | 30% Coinsurance [4] |
| Occupational therapy | | |
| • Inpatient | $500 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Hospice, or Skilled Nursing Facility) | 30% Coinsurance [4] |
| • Outpatient (up to 80 visits per Calendar Year if Medically Necessary) [5] | $40 Copayment per visit | 30% Coinsurance [4] |
| Speech and Hearing therapy (up to 80 visits per Calendar Year if Medically Necessary) [5] | $40 Copayment per visit | 30% Coinsurance [4] |
| **TRANSPLANTS** [1] | $500 Copayment per admission | **Not Covered** |

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| CITY of RIO RANCHO – Copay Plan (HWG20000)<br>BENEFITS AND COVERAGE | In-network Copayment/Coinsurance | Out-of-network Coinsurance |
|---|---|---|
| **COMPLEMENTARY THERAPIES**<br>(Limited) | | |
| Acupuncture services (up to 20 visits per Calendar Year if Medically Necessary) | $40 Copayment per visit | **Not Covered** |
| Chiropractic services (up to 20 visits per Calendar Year if Medically Necessary) | $40 Copayment per visit | **Not Covered** |
| Biofeedback for specific conditions | $40 Copayment per visit | **Not Covered** |
| **SKILLED NURSING FACILITY** (1)<br>(Up to 60 days per Calendar Year)(5) | $500 Copayment per admission (waived if transferred directly from an Inpatient Hospital, rehabilitation, or Hospice facility) | 30% Coinsurance (4) |
| **HOME HEALTHCARE SERVICES** (1)/<br>**HOME INTRAVENOUS SERVICES** (1) | | |
| Services provided by a registered nurse (RN), licensed practical nurse (LPN) and other specified specialist | $40 Copayment | 30% Coinsurance (4) |
| Home intravenous services and supplies | $40 Copayment | 30% Coinsurance (4) |
| Medical Drugs (1) Oral or inhalation forms/self-Administered | 15% Coinsurance | 30% Coinsurance |
| Medical Drugs (1) Intravenous (IV) | 15% Coinsurance | 30% Coinsurance |
| **HOSPICE CARE** (1) | | |
| Inpatient | $500 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Rehabilitation, or Skilled Nursing Facility) | 30% Coinsurance (4) |
| In-home | $0 Copayment | 30% Coinsurance (4) |
| **DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES**(1) | 30% Coinsurance | 50% Coinsurance (4) |
| Hearing Aids (for school-aged children under age 18 or 21 years of age if still attending high school) | Every 36 months per hearing-impaired ear | Every 36 months per hearing-impaired ear |

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***(5) Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.***

| CITY of RIO RANCHO – Copay Plan (HWG20000)<br>BENEFITS AND COVERAGE | In-network<br>Copayment/Coinsurance | Out-of-network<br>Coinsurance |
|---|---|---|
| **EYEGLASSES AND CONTACT LENSES (1)**<br><br>Limited to the following: | | |
| • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus, or when related to Genetic Inborn Errors of Metabolism | 50% Coinsurance | **Not Covered** |
| • Refraction eye exam associated with post-cataract surgery or Keratoconus correction | Included in office visit Copayment | **Not Covered** |
| **DENTAL SERVICES/ (CMJ/TMJ)** (Limited) | Included in office visit Copayment | 30% Coinsurance |
| **FAMILY, INFANT AND TODDLER PROGRAM**<br><br>*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, Chapter30, Part 8 Health Family & Children Healthcare Services* | No Copayment<br>$3,500 per Participant per Plan Year<br>Maximum annual benefit<br>Not applicable to any lifetime maximums or annual limits. | **Not Covered** |

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## Introduction

City of Rio Rancho has contracted with Presbyterian Health Plan, Inc. (PHP) to provide you Coverage through a Point-of-Service (POS) plan hereafter referred to as the "Plan" or "Agreement." People who receive healthcare benefits through a POS are sometimes called "Enrollees" or "Subscribers." In order to be eligible to enroll and continue to participate in this plan, you must meet eligibility requirements established by City of Rio Rancho and meet all of the terms and conditions for such Coverage as outlined in the **Eligibility, Enrollment and Effective** Dates Section. PHP strives to work closely with Subscribers, their Covered Dependents, and their healthcare Providers/Practitioners to prevent illness and provide quality, cost-effective healthcare. Because of this close working relationship, PHP refers to its Enrollees and Subscribers as Members of our health plan.

The Plan Sponsor is City of Rio Rancho. The Third-Party Administrator is Presbyterian Health Plan.

City of Rio Rancho offers Copay Plan.

The POS plans allow you to choose, at the time you receive Services, the level of benefits that will apply. You receive the highest benefit level with the lowest cost to you when you obtain Services from a Participating Provider/Practitioner. City of Rio Rancho generally allows the designation of a Primary Care Provider (PCP). You have the right to designate any Primary Care Provider who participates in our network and who is available to accept you or your family members. Until you make this designation, City of Rio Rancho designates one for you. For children, you may designate a pediatrician as the Primary Care Provider. For information on selecting a Primary Care Provider and for a list of the participating Primary Care Providers, contact the Presbyterian Customer Service Center (PCSC) at **(505) 923-5208** or toll-free at **1-877-752-4164**, Monday through Friday from 7 am. to 6 p.m. TTY users may call **711.** The PHP Provider Directory lists the Participating Providers/Practitioners, which is available on our website, **www.phs.org**.

As a Member of this Plan, you must carefully follow all procedures and conditions for obtaining care as described throughout this Summary Plan Description (SPD). Certain procedures described in this SPD require **Prior Authorization.** Your Participating Provider/Practitioner must obtain this **Prior Authorization** from PHP before providing these Services to you.

Some non-Participating Providers/Practitioners, who are also out-of-state (outside of New Mexico), may be considered National Network Provider Providers (see definition in Glossary of Terms). Services provided by these National Network Providers will be administered at the "in-network" level of care. For Plan B, all Coinsurance amounts paid will apply toward the In-network Annual Out-of-pocket maximum. **However, the Member is responsible for obtaining Prior Authorization, if required. A 20 percent penalty is applied if Prior Authorization is not obtained for out-of-network Services or National Network providers.**

## How the Plan Works

### In-Network Providers

As a Member of this POS Plan, you will generally not have claims to file or papers to fill out in order to be reimbursed for medical Services obtained from Participating Providers/Practitioners. Your Participating Provider/Practitioner will bill us directly.

PHP does not require participating Providers/Practitioners to comply with any specified numbers, targeted averages, or maximum duration of patient visits.

An office visit is subject to a Copayment. All other Services billed separately with the office visit are subject to a separate Copayment or Coinsurance. If Services are included with the office visit charges, only the Copayment for the office visit applies. Refer to your *Summary of Benefits* for the amount of your Copayment or Coinsurance for each service. The Coinsurance will be applied to the Total Allowable charges or billed charges, whichever is less, for the procedure allowed by PHP.

Most medical Services and Hospital admissions require Copayment or Coinsurance at the time of service. The amount of your Copayment or Coinsurance is found in your *Summary of Benefits.* The Coinsurance is the percentage of Covered charges that you must pay for Covered Services.

### Provider Directory

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

If you need additional information about a Provider or would like to report an inaccuracy in the Provider Directory, you may call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711 or 1-877-298-7407**. Additionally, you may submit a Provider Directory inaccuracy report online at **https://www2.phs.org/providers?directory_type=php&insurance_plans=AHPH** and by navigating to the identified Provider's details page and choosing the *Report Inaccuracies* option.

The Provider Directory is subject to change and you should always verify the Practitioner/Provider's network status by visiting our website at **https://www2.phs.org/providers?directory_type=php&insurance_plans=AHPH**

If our Provider Directory lists inaccurate information that you relied on in choosing a Provider, you will only be responsible for paying your In-network Cost-sharing amount for care received

from that Provider. Please refer to the **Summary of Health Insurance Grievance Procedures Section** to understand your rights for filing an appeal.

## National PPO Network Providers

You can also obtain covered Services outside of New Mexico from National Network Providers. Your Deductible, Copayment and/or Coinsurance will be the same as if you received the Services from a Participating Provider. You can contact a Presbyterian Customer Service Center representative to help you locate an out-of-state National Network provider. However, National Network Providers are not considered "Participating Providers." If a covered service requires **Prior Authorization**, you are responsible for obtaining that Prior Authorization before receiving that covered service from Out-of-network Providers or National Network Providers. If you fail to obtain **Prior Authorization** when required, you will be responsible for a 20 percent penalty for covered Services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

You will not have any claims to file or papers to fill out in order to be reimbursed for medical Services obtained from Participating Providers and out-of-state National Network Providers. Your participating Provider or out-of-state National Network Provider will bill us directly. Most doctor visits and Hospital Admissions do require Copayment at the time of service. The amount of your Copayment for each service can be found in the *Summary of Benefits*.

## Out-of-Network Providers/Practitioners

Out-of-network Benefits, as found in the *Summary of Benefits*, apply when you obtain care from a Provider who is not a Participating Provider/Practitioner.

If you receive care from Providers/Practitioners who are non-Participating, payments by PHP 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 Deductible or Coinsurance.** Reasonable and Customary Charges are defined in the **Glossary** of Terms Section. If a Participating Provider/Practitioner recommends or refers you to a non-Participating Provider/Practitioner, Services provided to you by that non-Participating Provider/Practitioner are subject to the Out-of-Network benefits as shown in the *Summary of Benefits*. **Some Services are subject to a Copayment, as found in the *Summary of Benefits.***

Non-participating 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 PHP.

Please send your bill or claim to us at the following address:

**Presbyterian Health Plan**
**P.O. Box 27489**
**Albuquerque, NM 87125-7489**

Please refer to your *Summary of Benefits* and this Agreement for a complete listing of Covered Services.

For Services requiring **Prior Authorization,** you are responsible for ensuring that a **Prior Authorization** has been obtained before receiving Services from non-Participating Providers/Practitioners.

## Prior Authorization

**Certain procedures or Services, as identified in the Prior Authorization Section of this Summary Plan Description (SPD), do require Prior Authorization.** The responsibility for obtaining this **Prior Authorization** is as follows:

- In-network - When accessing In-network Benefits, the Participating Provider/ Practitioner is responsible for obtaining **Prior Authorization** from PHP or PHP's designee before providing these Services to you.
- Out-of-network - When accessing Out-of-network Benefits, you are responsible for obtaining **Prior Authorization** from PHP or PHP's designee before obtaining the Out-of-network Services.
- This requirement also includes care provided by National Network Provider providers. If **Prior Authorization** is not obtained when required, the Member is responsible for a 20 percent penalty.

**Note:** If you lose Coverage under this plan, **Services received after Coverage ends will not be Covered,** even if **Prior Authorization** was obtained from PHP. Obtaining **Prior Authorization** does not guarantee you will receive benefits.

## Important Instructions

This Agreement describes your benefits, rights and responsibilities as a Member of the Plan. It also details what limits are placed on certain benefits and what Services are not Covered at all. Please take the time to read this Summary Plan Description (SPD) carefully and then store it in a safe place for future reference. If you have any questions after reading this SPD, please contact City of Rio Rancho Human Resources Department or call the Presbyterian Customer Service Center at **(505) 923-5208** or toll-free at **1-877-752-4164**, Monday through Friday from 7 a.m. to 6 p.m. TTY users may call **711**. You may also visit Presbyterian's website at **www.phs.org.**

Help is available if you need assistance with completing PHP forms, have special needs, or need assistance in protecting your rights as a PHP Member. Call a PHP Consumer Assistance Coordinator at **(505) 923-5208** or toll-free at **1-877-752-4164.** TTY users may call toll-free **711**. You may also visit Presbyterian's website at **www.phs.org.**

PHP may be contacted in writing at the following address:

**Presbyterian Health Plan**
**P.O. Box 27489**

**Albuquerque, New Mexico 87125-7489**
**Attention: Customer Service Center**

## General Information

**Medical Necessity**
This healthcare benefit plan helps pay for healthcare expenses that are Medically Necessary and Specifically Covered in this Summary Plan Description (SPD).

- Medical Necessity or Medically Necessary means appropriate or necessary Services as determined by a Provider/Practitioner, in consultation with Presbyterian Health Plan (PHP). These services are provided to a Member for any Covered condition requiring, according to generally accepted principles of good medical practice guidelines. These guidelines are developed by the federal government, national or professional medical societies, boards, and associations, or any applicable clinical protocols or practice guidelines developed by PHP 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.

  **PHP determines whether a healthcare service or supply is Medically Necessary. 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.**

- Specifically Covered means only those healthcare expenses that are expressly listed and described by this Summary Plan Description (SPD).

  **PHP determines whether a healthcare service or supply is a Covered Benefit. The fact that a Provider/Practitioner has prescribed, ordered, recommended or approved a healthcare service or supply does not guarantee that it is a Covered Benefit even if it is not listed as an Exclusion**.

**Specifically Covered Benefits** are subject to the following:
- **The limitations, exclusions** and other provisions of this SPD; and
- **Payment by the Member** of the Deductible, Copayment or Coinsurance amount, if any, directly to the Provider/Practitioner of healthcare Services at the time Services are rendered.

**No Need to file Claim Forms When You Visit a Participating Provider/Practitioner**
You won't have any claims to file or claim forms to fill out for medical Services obtained from Participating Providers/Practitioners. Your Participating Provider/Practitioner will bill PHP directly. Most medical Services do, however, require a Copayment, Coinsurance or Deductible at the time of service. The amount of your responsibility for each service can be found in your *Summary of Benefits.*

Non-participating Providers/Practitioners may require payment in full at the time of service; you should then file your claim for reimbursement with Presbyterian Health Plan.

**Court Ordered Coverage for Dependent Children**
When a Subscriber has been ordered by a court to provide health insurance Coverage for a Dependent child who is eligible for the plan, Coverage will be provided, and regular In-network and Out-of-network benefits will be administered regardless of if the Dependent lives in or out of the PHP Service Area.

**Non-Custodial Parents**
When a child has Coverage through a non-custodial parent, PHP shall provide such information to the custodial parent as may be necessary for the child to obtain Benefits through that Coverage.

**Annual Calendar Year Deductible**
For Copay Plan (Out-of-network only), Services are subject to an annual Calendar Year Deductible. The amount of your annual Calendar Year Deductible can be found in your *Summary of Benefits.* This Deductible must be paid for by a Member each Calendar Year toward Covered Services before health benefits for that Member will be paid by PHP.

For single Coverage, the annual Calendar Year Deductible requirement is fulfilled when the Member meets the individual Deductible, listed in the *Summary of Benefits*, during the Calendar Year.

For Employee + One or family Coverage, with two enrolled Members, the annual Calendar Year Deductible requirement is fulfilled when both Covered Members have each met their applicable individual Deductible, listed in the *Summary of Benefits*, during the Calendar Year.

For family Coverage, with three or more enrolled Members, the family Deductible listed in the *Summary of Benefits* requirement is fulfilled when any three Covered Members have each met their applicable individual Deductible, listed in the *Summary of Benefits*, during the Calendar Year.

Covered charges for Participating Provider/Practitioner in-network Services do not apply to the non-Participating Provider/Practitioner out-of-network Deductible and vice versa.

**Annual Out-of-Pocket Maximum**
Copay Plan includes an Annual Out-of-pocket Maximum amount to help protect you from catastrophic healthcare expenses. After your Annual Out-of-pocket Maximum is reached in a Calendar Year, the Plan pays 100 percent, up to allowable charges, for Covered Services for the remainder of that Calendar Year, up to the maximum benefit amounts, if any. Refer to your *Summary of Benefits* for the Annual Out-of-pocket Maximum amounts.

For single Coverage, the Annual Out-of-pocket Maximum requirement is fulfilled when the Member meets the individual Out-of-pocket Maximum, listed in the *Summary of Benefits,* during the Calendar Year.

For Employee + One or family Coverage, with two enrolled Members, the Annual Out-of-pocket Maximum requirement is fulfilled when both Covered Members have each met their applicable Individual Out-of-pocket Maximum listed, in the *Summary of Benefits,* during the Calendar Year.

For family Coverage, with three or more enrolled Members, the Family Annual Out-of-pocket Maximum requirement is fulfilled when any three Covered Members have each met their applicable Individual Out-of-pocket Maximum, listed in the *Summary of Benefits*, during the Calendar Year.

The Annual Out-of-pocket Maximum includes Coinsurance and Deductible only and does **not** include copayments, penalty amounts, or non-Covered charges.

Covered charges for Participating Provider/Practitioner (In-network) Services do not apply to the non-Participating Provider/Practitioner (Out-of-network) Out-of-pocket Maximum, or vice versa.

**Transition of Care**

If a new Member is in an ongoing course of treatment with a non-Participating Provider/Practitioner, the Member will be allowed to continue receiving care from this Provider/Practitioner for a transitional period of time as set forth in the Continuation of Coverage Section. Similarly, if the Member is in an ongoing course of treatment with a Participating Provider/Practitioner and that Provider/Practitioner becomes a non-Participating Provider/Practitioner, the Member will be allowed to continue care from this Provider/Practitioner for a transitional period of time as set forth in the Continuation of Coverage Section. In any case, the transitional period of time shall not be less than **30 days** but may be longer depending on your medical needs. Please call Presbyterian Customer Service Center at **(505) 923-5208** or toll-free at **1-877-752-4164** for further information about Transition/Continuity of Care.

**Utilization Management Procedures**

PHP's Care Coordination Department is staffed with registered nurses that coordinate Covered health Services for Members with ongoing or complex diagnoses. The role of the nurse care coordinator is to support and educate the Member so they are able to make informed healthcare decisions. Ongoing communication and visits to Members who may have a chronic illness can trigger prompt intervention and help in the prevention of avoidable episodes of illness. PHP is committed to the personal service that care coordination provides to its Members in need.

Our nurse care coordinators can work with the Hospital discharge planners when you are in the Hospital to determine the length of stay you need and coordinate your care after you leave the Hospital.

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

**Health Management Programs**
PHP's clinically trained professionals work with your doctor to help enhance your quality of life in three areas: staying healthy, living with illness, and getting better. The Plan helps 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'd like more information about these Services, please call Presbyterian Customer Service Center at **(505) 923-5208** or toll-free at **1-877-752-4164**, Monday through Friday from 7 a.m. to 6 p.m. TTY users may call **711**. You may visit Presbyterian's website at **www.phs.org**.

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

If you suspect that a Provider, Hospital or other Provider/Practitioner has:

- 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 suspect any other suspicious activity, please contact Presbyterian Compliance, Ethics and Privacy Hotline at **(505) 923-5959** or toll-free at **1-888-435-4361**, Monday through Friday from 8 a.m. to 5 p.m.

Anyone, who knowingly presents a false or fraudulent claim for payment of a loss or knowingly presents false information for Services, is guilty of a crime and may be subject to civil fines and criminal penalties. The Plan may terminate a Member for any type of fraudulent activity. Some examples of fraudulent activity include, but are not limited to:

- Falsifying enrollment information
- Allowing someone else to use your ID card
- Forging or selling prescriptions
- Misrepresenting a medical condition in order to receive benefits to which you would not normally be entitled
- Not notifying the Plan when a Covered Dependent no longer meets eligibility

## Eligibility, Enrollment and Effective Dates

### Who is Eligible?

1. Subscribers. To be eligible to enroll as a Subscriber, you must:
   a. Meet City of Rio Rancho eligibility requirements; and
   b. Be a permanent employee of City of Rio Rancho, currently working a minimum of **20 hours** per week; and
   c. Be eligible to participate in medical and Hospital benefits arranged by City of Rio Rancho; and
   d. An employee cannot carry duplicate benefit coverage; if both you and your spouse work for the same employer, you may not enroll each other as an eligible spouse on any plan described in this booklet, nor may you both cover your children. Double coverage outside the City of Rio Rancho Employer-Sponsored Group Benefits Plan is allowed;
   e. Meet any other eligibility criteria as specified by City of Rio Rancho.

2. Dependents. To be eligible to be enrolled as a Dependent for purposes of Coverage as a Member of the Plan, an individual must:
   a. Be your legally married spouse, as defined by state law and physically live in PHP's Service Area as defined by PHP; or
   b. Be your Domestic Partner who is not employed by the City of Rio Rancho; Domestic Partners are defined as couples who are in an exclusive and committed relationship for mutual benefit, similar to that of marriage. Domestic Partners must share a common, primary residence for 12 or more consecutive months and must be jointly responsible for each other's common welfare, as well as shared financial obligations. Domestic Partners must be at least 18 years of age and may not be married, nor can they be a member of another domestic partnership. Domestic partners are also forbidden from being blood relations to a degree of closeness that would prevent them from being married in their state of residence. A signed Affidavit of Domestic Partnership must be provided to the City of Rio Rancho Human Resources in order for a partner to be added as a Dependent;
   c. Be your Dependent child who is:
      (1) Under 26 years of age;
      (2) Your own or legally adopted child or a child for whom you are a legal guardian or have legal custody as defined by state law;
      (3) In your Custodial Care as appointed by court order;

**Note:** Only the eligible court-ordered Dependent will be allowed to enroll. The eligible Dependent will become effective on the date in accordance with the court order. If the court order does not stipulate an effective date, the Dependent will become effective the first of the month following the date the court order was filed with the court. In a case where the employee was not previously compliant with the order, the effective date for the Dependent will be the first of the month following receipt of the request by the employer. The employee of the Dependent must meet any applicable waiting periods imposed by the Group, and only the eligible, court-ordered Dependent will be allowed to enroll. The City of Rio Rancho's waiting period requirement for all employees is the first of the month following **30 days** of employment.

(4) Children of Domestic Partners. Benefits are also available to domestic partner's children provided that the child is primarily dependent upon the employee or domestic partner for support and one or both of the domestic partners is the biological child of the parent, adoptive parents of the child, or the child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or court order with the exclusion of foster children;
(5) Your stepchild (foster children are not eligible);
(6) A child for which a court or qualified administrative order is imposed or a child of non-custodial parent(s) who depends on you for support. Dependent children who are eligible to be enrolled under this item two. Subsection b. are not required to live in the Service Area. City of Rio Rancho may require proof of eligibility. Enrollment of a Dependent child under this Contract shall terminate upon attainment of the child's 26th birthday, except as provided in item two. Subsection d. below or earlier marriage; or

d. Be your or your spouse's Dependent child, under 26 years of age, for whom you are required by court order to provide healthcare Coverage. Dependent children who are eligible to be enrolled under this item two. Subsection c. are not required to live in the Service Area, and Coverage is provided as described in the **General Information** Section. Enrollment of a Dependent child under this Contract shall terminate at the end of the month upon attainment of the child's 26th birthday.
e. The attainment of the limiting age referenced in item two. Subsections b. and c., above, shall not terminate the Coverage under this Agreement of a Dependent unmarried child who is totally and permanently disabled. The Dependent must be incapable of self-sustaining employment by reason of mental disability or physical handicap and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish proof of such disability, incapacity and dependence to City of Rio Rancho within **30 days** of the Dependent child's attainment of age 26, and each birthday thereafter if requested by City of Rio Rancho.

## Enrollment and Effective Dates

Eligible Subscribers and Dependents may enroll at the following times and in the following manner:

1. Together with eligible Dependents, subscribers may enroll by submitting completed application forms to City of Rio Rancho. The signed and completed application form must be received by City of Rio Rancho within **30 days** of the effective date.
2. Subscribers and eligible Dependents may begin receiving Services for Covered Benefits at 12:01 a.m. on the first day of the month following the date of hire if the names of the Subscribers and eligible Dependents have been received in writing by City of Rio Rancho. (If the date of hire is on the first day of the month, then coverage begins at 12:01 a.m. on that day.) Please contact City of Rio Rancho Human Resources for details.
3. Newly hired employees of City of Rio Rancho must enroll within **30 days** after becoming eligible. The effective time and date of Coverage will be 12:01 a.m. on the first of the month following completion of City of Rio Rancho's eligibility requirements. If

enrollment is not accomplished within the **30-day** period, the next earliest time the eligible Subscriber and eligible Dependents may enroll is the next occurring Annual Enrollment Period except as specifically described below.

4. A child for whom a Subscriber becomes a legal guardian pursuant to court order is eligible to be enrolled as a Dependent for the duration of the guardianship unless otherwise ineligible for Coverage. Such a child must be enrolled within **30 days** of the date of the court order granting guardianship. The Dependent will become a Member on the first day of the month following the date the order is filed with the clerk of the court.
5. A child for whom a Subscriber has been ordered by a court of law/qualified administrative order to provide healthcare Coverage is eligible to be enrolled as a Dependent provided that the Subscriber has met City of Rio Rancho's waiting period requirements and the request for enrollment is made within **30 days** from the date on which City of Rio Rancho receives the court/qualified administrative order. The City of Rio Rancho's waiting period requirement for all employees is the first of the month following **30 days** of employment. The Dependent will become a Member on the day stipulated by the court order.
6. An eligible person may enroll as a Subscriber or Dependent after the initial eligibility period if the person loses Coverage under all of the following circumstances:
    a. The person was Covered under a Group health plan or had individual health insurance Coverage at the time the person was initially eligible to enroll; and
    b. The employee stated in writing if requested by City of Rio Rancho at the time the employee was initially eligible to enroll, that he and/or his Dependents were not enrolling because of such other Coverage; and
    c. The person's Coverage under the other plan or insurance:
        (1) Was under a COBRA continuation provision, and the Coverage under that provision was exhausted (and not voluntarily terminated);
        (2) Was not under a COBRA continuation period, and either the Coverage was terminated as a result of loss of eligibility or employer contributions toward the Coverage were terminated; and
    d. Application was made within **30 days** of the date Coverage under COBRA was exhausted, or the date the Coverage (or the employer's contribution toward Coverage) was terminated.
7. Upon expiration of any applicable **30-day** period for eligibility, enrollment in this Plan can occur only during a subsequent Annual Enrollment Period.

## Family Status or Employment Status Changes

Notwithstanding the provisions specified in item C. (Special Enrollment) of this Section, Subscribers may make certain changes to their benefit elections within **30 days** or, as specified by City of Rio Rancho, of a change in family/employment status. Evidence of a change in family/employment status must be provided to City of Rio Rancho in order to change a Subscriber's benefit elections. Any change in Coverage will become effective on the date of the event of the status change provided the completed request for enrollment is received by the plan within **30 days.** Termination of a Dependent is not a qualifying event for the Subscriber to

change benefit plans. The following family/employment status changes are recognized by City of Rio Rancho as:

1. Marriage
   a. A Subscriber's newly acquired spouse (and any child of the spouse eligible for Coverage under item A. of this Section) is eligible to be enrolled as a Dependent. Such newly acquired spouse must be enrolled within **30 days** from the date of marriage. Coverage will become effective on the date of marriage.
2. Divorce or legal separation;
3. Birth or adoption of a child.
   a. Newborns of a Subscriber or Subscriber's spouse will be Covered from the moment of birth when enrolled if the signed and completed Enrollment Application form must be submitted to and received by City of Rio Rancho within **30 days** from the date of birth. Otherwise, the newborn cannot be enrolled for Coverage until the next following Annual Enrollment Period. Please refer to **Benefits** Section, Women's Healthcare, **Prior Authorization** Section, and the **Limitations and Exclusions** to fully understand the benefits and requirements for Maternity and newborn Coverage.
   b. A child for whom the Subscriber has commenced adoption proceedings is eligible to be enrolled as a Dependent. The child will be Covered from the date of placement for the purpose of adoption if the child is enrolled and any applicable Prepayment made within **30 days** of the date of placement. The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of the child's adoption. 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.
4. Death of a spouse or Dependent child;
5. A change in the Subscriber's spouse's employment (loss of job, or a new job that provides Dependent care assistance or other healthcare Coverage, however, annual enrollment for a spouse's plan is not a family status change);
6. A change in legal responsibility for a child;
7. The 26th birthday of a Dependent child (coverage will term at the end of the birthday month);
8. Marriage of a Dependent child;
9. Court order/qualified administrative order to provide health insurance for an eligible Dependent;

   **Note:** Only the eligible court-ordered Dependent will be allowed to enroll. The eligible Dependent will become effective on the date in accordance with the court order. If the court order does not stipulate an effective date, the Dependent will become effective the first of the month following the date the court order was filed with the court. In a case where the employee was not previously compliant with the order, the effective date for the Dependent will be the first of the month following receipt of the request by the employer. The employee of the Dependent must meet

any applicable waiting periods imposed by the City of Rio Rancho, and only the eligible, court-ordered Dependent will be allowed to enroll. The City of Rio Rancho's waiting period requirement for all employees is the first of the month following **30 days** of employment. The Subscriber is not eligible to enroll until the next annual enrollment period.

10. Disqualification or requalification of a Dependent;
11. Disqualification or requalification of a domestic partner;
12. Unpaid leave of absence for either the Subscriber or spouse due to a serious health condition;
13. Bankruptcy;
14. Change in employment status (regular part-time to regular full-time or vice versa);
15. Significant change in the cost of a spouse's current plan (50 percent or greater); and
16. An employment transfer that results in a change of residence.

## Special Enrollment/Notice of Employee Rights

1. An employee who failed to enroll in this Plan during a previous enrollment period but who would otherwise be eligible for Coverage may enroll in this Plan due to a Special Enrollment event. Application must be made within **30 days** of acquiring a new Dependent through marriage, birth, adoption or placement for adoption or as specified by City of Rio Rancho. Special Enrollment applies to the Subscriber, spouse and "Eligible Dependents," which include the new Dependents acquired because of the marriage or newborn/adopted children who triggered the event, but not other siblings.
2. Effective date of enrollment:
    a. In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan, provided it is received within **30 days** of the date of marriage.
    b. In the case of a Dependent's birth, the date of such birth; and
    c. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.
3. CHIPRA (in accordance with provisions as currently may be defined under Federal law).
    a. An employee, who chose not to enroll in this Plan for self and/or Dependent(s) during a previous enrollment period because they were Covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, may request coverage for self and/or any affected eligible Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of the date Medicaid or CHIP coverage terminated.
    b. An employee, who chose not to enroll in this Plan for self and/or Dependent(s) during a previous enrollment period and has become eligible for group health premium assistance under State Medicaid or State CHIP, may request coverage for self and/or eligible Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of becoming eligible.

c. 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.

## Rescission

Rescission is a cancellation or discontinuance of coverage that has a retroactive effect.

PHP cannot rescind coverage with respect to a Member once the enrollee is Covered under this Plan (Copay Plan) unless the enrollee performs an act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact. PHP must provide at least **30 days** advance written notice to each participant who will be affected before coverage can be rescinded.

In order to understand what constitutes fraud, refer to **General Information** Section Fraud.

# Benefits

Benefits are subject to the Copayments and Coinsurance listed in the *Summary of Benefits.* Please refer to the **Limitations and Exclusions** Section applicable to this Plan. **Any Services received must be Medically Necessary to be covered**.

**Note:**
If you disagree with PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See the **Grievance Procedure** Section.

## Accidental Injury/Medical Emergency Care/Urgent Care

**Medical Emergency Care**
This Plan covers acute Emergency Health Services **24 hours** a day, **seven days** a week when those Services are needed immediately to prevent jeopardy to a Member's health. Benefits are available for Emergent and Urgent Services received outside the United States. If Emergency Health Services are administered by either a Participating or non-Participating Provider, benefits for the initial treatment are paid at the In-network benefit level. Non-Participating Providers/Practitioners will be reimbursed by this Plan up to Reasonable and Customary Charges. You will be responsible for any charges above Reasonable and Customary when considered a non-emergency service.

If the Member is hospitalized within **48 hours** of Emergency Health Services, the entire hospitalization will be considered part of the initial treatment. Once the Member is discharged, follow-up care received through a non-Participating Provider/Practitioner will be paid at the Out-of-network benefit level.

A Member who, as a result of Emergency Health Services, is admitted to a non-Participating Hospital may choose to be transferred to a Hospital participating in the PHP Provider/Practitioner network to receive Services at the In-network benefit level. The Member must be medically stable and can be safely transferred. If the Member chooses to remain at an Out-of-network Hospital, Out-of-network benefits will apply.

This Plan will provide reimbursement when a Member, acting in good faith, obtains Emergency Health Services for what reasonably appears to the Member, acting as a reasonable layperson, to be an acute condition that requires immediate medical attention, even if the patient's condition is subsequently determined to be non-emergent.

In determining whether the Member acted as a "reasonable layperson" as described in item c. above, PHP 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 the Member from using PHP's established procedures for obtaining Services.

**Prior Authorization** is not required for Emergency Health Services.

For Emergency Health Services outside PHP's Service Area, the Member 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 a non-Participating Provider/Practitioner is Covered as Out-of-network services.

All Emergency Health Services, Urgent Care and Trauma Care Services, whether provided within or outside of PHP's Service Area, are subject to the limitations listed in the **Limitations and Exclusions** Sections.

**Urgent Care**
Urgent Care means Medically Necessary Healthcare Services provided in non-life-threatening situations or after a Primary Care Provider's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

These are situations that are not life-threatening but require prompt medical attention or Urgent Care. Examples of Urgent Care situations include but are not limited to sprains, high fever, minor cuts, minor burns, requiring stitches, significant vomiting or diarrhea, severe stomach pain, swollen glands, rashes, poisoning, strains, cramps, bumps, bruises and back pain.

You will be reimbursed for all Services rendered that satisfy this definition unless otherwise limited or excluded if provided by a licensed Provider and/or an appropriate facility for treating urgent medical conditions. Members are encouraged to contact their In-network PCPs for an appointment, if available, before seeking care from another In-network Provider. Members may contact the Presbyterian Customer Service Center for information regarding the closest In-network facility that can provide Urgent Care.

If a Member believes the condition to be treated is life-threatening, the Member should seek Emergency Health Services as outlined above.

**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 an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation, it is on the Providers/Practitioners written order. To transition from observation to an Inpatient admission, level of care criteria used by PHP must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient stays.

**Ambulance Services**
The following types of Ambulance Services are Covered: (1) Emergency Ambulance Services, (2) High-Risk Ambulance Services, and (3) Inter-Facility Transfer Services.

**Emergency Ambulance Services** are defined as ground or air Ambulance Services delivered to a Member who requires 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 PHP's Service Area, to the nearest Participating Hospital where emergency medical treatment can be rendered, or to a non-Participating Hospital if a Participating Hospital is not reasonably accessible. Such Services must be provided by a licensed Ambulance service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside PHP'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.
- This 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 the Member's 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 an individual authorized under state law to make such pronouncements had dispatched the ambulance prior to the pronouncement of death.
- Member will be responsible for any balance due above Reasonable and Customary Charges for out-of-network air ambulance service.
- In determining whether the Member "acted in good faith" as a "reasonable layperson" when obtaining emergency Ambulance Services, PHP will consider the following factors:
    - Whether the Member required Emergency Health Services, as defined above;
    - The presenting symptoms;
    - Whether a layperson who possesses an average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered the Member's health;
    - Whether the Member was advised to seek an ambulance by his/her Provider or by PHP. Any such advice will result in reimbursement for all Medically Necessary Services rendered, unless otherwise limited or excluded under this Agreement.

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

- Non-emergency; and
- Medically Necessary for transporting a high-risk patient; and
- Prescribed by the Member's Provider.

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

- Air Ambulance Service when Medically Necessary. However, this 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 the Member's 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 any of the following: Hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer Services are Covered only if they are:

- Medically Necessary;
- Prescribed by the Member's Provider; and
- Provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.

## Clinical Trials

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

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

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

- Conducted under an investigational new drug application reviewed by the Food and Drug Administration;
- A drug trial that is exempt from having such an investigational new drug application; or
- Is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

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

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

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

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

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

**Exclusions:**
In addition to the exclusions listed in the **Exclusions** Section, the following are not Covered:

- Any Clinical Trials that do not meet the requirements indicated in items one through five above.
- Costs of the Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.
- Services from non-Participating Providers/Practitioners, unless Services from a Participating Provider/Practitioner are not available.

- The cost of a non-FDA-approved Investigational drug, device or procedure.
- The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Clinical Trial.
- Cost associated with managing the research that is associated with the Clinical Trial.
- Costs that would not be Covered if non-Investigational treatments were provided.
- Costs of tests that are necessary for the research of the Clinical Trial.
- Costs paid or not charged for by the Clinical Trial Providers.

## Clinical Prevention Services

Coverage is provided for the following preventive Services at an age and frequency as determined by the Member's healthcare 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; and
    - Periodic stool examination for the presence of blood.
    - 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 (AAP).
- Adult and Child Immunizations (shots or vaccines), in accordance with the recommendations of the AAP, the Advisory Committee on Immunization Practices, or the United States 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 Services Task Force for determining the presence of precancerous or cancerous conditions. Screening includes:
    - Fecal occult blood testing (FOBT),
    - Flexible Sigmoidoscopy,
    - Colonoscopy,
    - Double-contrast barium enema.
- 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 Members under 19 years of age, this includes (as deemed appropriate by the Member's Provider or as requested by the parents or legal guardian) education information on alcohol and Substance Use, sexually transmitted

infections (STIs), and contraception. For Members 19 years of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.

- 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.
- 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.
- Vaccine Coverage for HPV for females used for the prevention of HPV infection and cervical pre-cancers as approved by the Food and Drug Administration (FDA) and in accordance with guidelines established by The Advisory Committee on Immunization Practices (ACIP).

## Complementary Therapies

The only alternative/complementary therapies that are Covered are those that are identified in this Agreement.

**Acupuncture (Limited)**
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 the Member's Provider.
- Acupuncture Services are limited to a Calendar Year maximum for up to 20 visits. Refer to your *Summary of Benefits* for this maximum.
- Acupuncture Services received from non-Participating providers are 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 that chiropractic treatment will not exceed 20 visits per Calendar Year.
- 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 PHP, 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 PHP for chiropractic treatment.
- 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 half an inch, or spine curvature consistent with osteoporotic fractures; or
    - Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement.
- Treatment of conditions, other than headache, which do not have acute Subluxation demonstrable on exam are not Covered, including chronic Subluxation of rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/conditions as determined by PHP 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 Agreement.
- Chiropractic Services are limited to a Calendar Year maximum for up to 20 visits. Refer to your *Summary of Benefits* for this maximum.
- Chiropractic Services received from non-Participating providers are not Covered.

**Biofeedback (Limited)**
Biofeedback is only Covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence and must be received by a Participating Provider/Practitioner.

**Massage Therapy (Limited)**
Massage Therapy is only Covered when provided by a licensed physical therapist and as part of a prescribed short-term physical therapy program. **Benefits** Section, Rehabilitation and Therapy.

## COVID-19

As a Presbyterian Health Plan member, there will be no cost to you for anything related to COVID-19 screening, testing, medical treatment or vaccination. You will not pay copays, deductibles or coinsurance for visits related to COVID-19, whether at a clinic, hospital or using remote care. If you are on a high deductible plan (HDHP), these Services will also be provided to you at no cost.

## 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 situation as described in the **Benefits** Section.

- Accidental Injury to sound natural teeth, jawbones or surrounding tissue. Accidental Injury treatment is limited to Services received within 36 months of the date of the accident. Dental injury caused by chewing, biting or Malocclusion is not considered an Accidental Injury.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- The surgical and non-surgical treatment of Temporo/Craniomandibular disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) is subject to the same conditions, limitations, and 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 PHP. Plan benefits for these Services include coverage:
    - For Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;
    - For Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
    - For Covered children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
    - For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; and
    - For other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- Dental implants are not Covered.

## Diabetes Education

This 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). **Express Scripts** administers Prescription drugs, insulin or supplies. Please call **Express Scripts** at **1-866-217-3774.**

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 diagnosis that represents a significant change in condition or symptoms requiring changes in the patient's self-management; and
  - 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 members of a certified, registered or licensed healthcare professionals with recent education in diabetes management.
- Diabetes Supplies and Services. When prescribed by the Member's Provider, the following equipment, supplies, appliances, and Services are Covered for Members with diabetes:
  - Prescriptive insulin and diabetic oral agents for controlling blood sugar levels are provided by Express Scripts. Please call **Express Scripts** at **1-866-217-3774**.
  - Medically Necessary podiatric appliances for preventing foot 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 PHP.
  - Blood glucose monitors/meters (Durable Medical Equipment), approved by PHP.
  - Insulin pumps when Medically Necessary and prescribed by an endocrinologist and certified by PHP.

For additional diabetic supply coverage (e.g., insulin needles and syringes, lancets and lancets devices, test strips, glucagon emergency kits), call **Express Scripts** at **1-866-217-3774.**

## 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 and exclusions in the **Limitations and Exclusions** Section and the **Prior Authorization** requirements in the **Prior Authorization** Section. All Diagnostic Services must be provided under the direction of the Member's Provider. Examples of Covered procedures include, but are not limited to the following:

- Cardiac procedures including, but not limited to EKG, EEG, echocardiograms and MUGA scans;
- Clinical laboratory tests;

- CAT (Computerized Axial Tomography) scans;
- Endoscopy procedures;
- GI (gastrointestinal) lab procedures;
- MRI (Magnetic Resonance Imaging) tests;
- Pulmonary function tests;
- Radiology/X-ray Services;
- Ultrasound procedures;
- Sleep disorder studies;
- Bone density studies.

## Durable Medical Equipment and Appliances, Hearing Aids, Medical Supplies, Orthotics, and Prosthetics

**Durable Medical Equipment**
Durable Medical Equipment is equipment 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 and includes items such as oxygen equipment, wheelchairs and crutches. Rental, or at the option of PHP, the purchase of Durable Medical Equipment is Covered when required for therapeutic use, determined to be Medically Necessary by the Member's Provider and certified by PHP. Only Durable Medical Equipment considered standard and/or basic items are Covered.

**Exclusions:**

- Upgraded or deluxe items
- Items considered "for convenience." A convenience item is an appliance, device, object or service that is for comfort and ease and is not primarily medical in nature. Examples include, but are not limited to:
    - Shower stools/chairs/seats
    - Bath grab bars
    - Showerheads
    - Vaporizers
    - Wheelchair/walker/stroller accessories such as baskets, trays, seats or shades
- Duplicate DME items (i.e., for home and for office)

**Orthotic Appliances**
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 the Member's Provider and certified by PHP. Foot orthotics or shoe appliances are not Covered, except for Members with diabetic neuropathy or other significant neuropathy. Custom fabricated knee-ankle-foot orthoses (AFO and/or KAFO) are Covered for Members up to eight years old.

**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 the Member's Provider and when certified by PHP.

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. **Dental implants are not Covered.**

**Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices**
Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices are Covered when certified by PHP and when Medically Necessary due to change in the Member's condition, wear, or after the product's normal life expectancy has been reached.

**Exclusions**:

- 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 Member has a functional wheelchair, regardless of the original purchase of the wheelchair, additional wheelchair(s) are not Covered. One-month rental of a wheelchair is Covered if a Member owned the wheelchair that is being repaired.

**Surgical Dressing**
Surgical dressings that 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 Calendar Year for**:

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

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

**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 by 4's) and ace bandages, except when provided in a Hospital or Provider's office or by a home health professional
- Gloves unless part of a wound treatment kit
- Elastic support hose

**Eyeglasses and Contact Lenses (Limited)**
All eyeglasses or contact lenses are subject to the **Limitations and Exclusions** Sections. The following will only be Covered if received from Participating Providers/Practitioners**.**

Contact lenses are Covered for the correction of aphakia (those with no lens in the eye) or keratoconus. This includes the Eye Refraction examination.

One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is Covered within 12 months after Cataract Surgery or when related to Genetic Inborn Error of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.

**Exclusions relating to Eyeglasses and Contact Lenses:**

- Except as above, routine vision care, Eye Refractions, 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**
For school-aged children under 18 years old (or under 21 years of age if still attending high school), hearing aids and the evaluation for the fitting of hearing aids are Covered as follows:

- Every 36 months "per hearing-impaired ear" for school-aged children under 18 years old (or under 21 years of age if still attending high school)
- Shall include fitting and dispensing Services, including ear molds as necessary to maintain optimal fit, as provided by a Participating Provider/Practitioner licensed in New Mexico

## 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 the Prior Authorization Section requirements listed in the Summary Plan Description (SPD). Medical Services provided by licensed Healthcare Professionals, including Providers, dieticians and nutritionists, with

specific training in managing Members 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); and
- 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'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, and
- 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 foods coverage, contact **Express Scripts** at **1-866-217-3774**.

Please refer to your *Summary of Benefits* for applicable office visit, Inpatient Hospital, Outpatient facility, prescription drug and other related Copayments.

## Genetic Testing

A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites directly related to a manifested disease, disorder or pathological condition. Accordingly, a test to determine whether an individual has a BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, a human immunodeficiency virus (HIV) test, complete blood count, cholesterol test, liver function test or test for the presence of alcohol or drugs is not a genetic test. Genetic testing requires **Prior Authorization**.

## Habilitative

### Autism Spectrum Disorder

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

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

These Services are **only Covered when a treatment plan is provided to PHP'S Health Services Department prior to Services being obtained**. The Health Services Department will review the treatment plans in accordance with state-mandated benefits.

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

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

## Home Health Care

Home Healthcare Services are health Services provided to a Member 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 a Member's home when certified by PHP and when prescribed by the Member's Provider. Any such prescription or **Prior Authorization** must be renewed at the end of each **60-day** period. PHP will not impose a limitation on the number of related hours per visit.

- 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 which 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 a Provider for the provision of health Services in the home, **except Durable Medical Equipment**.
- Home healthcare or home intravenous Services as an alternative to hospitalization, as determined by the Member's Provider and as approved by PHP.
- Total parenteral and enteral nutrition as the sole source of nutrition when certified by PHP.
- Medical Drugs as described in this Section when provided by a Home Health Agency, and when certified by PHP. Refer to the Summary of Benefits for the required Coinsurance for Medical Drugs.

## Hospice Care

Inpatient and in-home Hospice Services are a Covered Benefit for terminally ill Members when Services are provided by a Hospice program approved by PHP during a Hospice benefit period (and **not Covered** to the extent that they duplicate other Covered Services available to the Member). Benefits are provided for a PHP participating Hospice or other facility when approved by the Member's Provider and certified by PHP. The Hospice benefit period must begin while the Member is enrolled in this plan, and Coverage through PHP must be continued throughout the benefit period in order for Hospice benefits to continue.

The Hospice benefit period is defined as follows:

- Beginning on the date the Member's Provider certifies that the Member is terminally ill with a life expectancy of six months or less; and
- Ending six months after it began, except as described in item c. below, or upon the death of the Member;
- If a Member requires an extension of the Hospice benefit period, the Hospice must provide a new treatment plan, and the Member's Provider must re-certify the Member's medical condition to PHP. No more than one additional Hospice benefit period will be certified by PHP.

The following Services will be Covered under the Hospice benefit (where a certified Hospice program is available):

- Inpatient Hospice care;
- Provider visits by Participating Hospice Providers;
- Home Healthcare 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; and

- Respite care for a period not to exceed five continuous days for every **60 days** of Hospice care. No more than two respite care stays will be available during a Hospice benefit period.

Hospice 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

**The following services are not Covered** under Hospice care but may be Covered elsewhere in this Summary Plan Description (SPD) subject to the Member's Deductible, Copayment and Coinsurance requirements:

- Acute Inpatient Hospital care for curative Services;
- Durable Medical Equipment;
- Provider visits by other than a Participating Hospice Provider; and
- Ambulance Services

Where there is not a certified Hospice program available, regular home healthcare Services benefits will apply. Refer to the **Benefits** Section, Home Healthcare Services/Home Intravenous Services and Supplies.

## Hospital Inpatient Services

Inpatient means a Member who has 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 Members who are registered bed patients, for which there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital.

Hospital admissions must be certified by PHP unless such Services constitute Emergency Health Services. Hospital Services must be provided under the direction of the Member's Provider.

Inpatient Hospital Services include, but are not limited to, the following when Medically Necessary, subject to the **Prior Authorization** requirements listed in the **Prior Authorization** Section, and the limitations and the exclusions contained in the **Limitations and Exclusions** Sections:

- Acute Medical Detoxification: Inpatient treatment for acute medical detoxification induced by alcohol or drug use shall be provided when Medically Necessary at an acute care facility or a treatment center specializing in Substance Use. Acute Medical Detoxification in a Residential Treatment Center is not Covered. Acute Medical Detoxification treatment must be approved in advance by the Member's Provider and must be certified by PHP. Acute Medical detoxification treatment must be certified by PHP
- Anesthetics, oxygen, and Covered medications
- Blood, blood plasma and blood components
- Diagnostic Services, as specified in the **Benefits Section**, Diagnostic Services
- 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 and surgeon Services
- Private room and board accommodations when Medically Necessary and certified by PHP
- Semi-private room and board accommodations, including general duty nursing care
- Special Services and procedures, such as special duty nursing, when certified by PHP
- Surgery, when certified by PHP. 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

## Mental Health and Alcoholism and/or Substance Use Disorder

**Mental Health Services**
For assistance in locating a provider, Members may call the PHP Behavioral Health Department directly at **(505) 923-5470** or toll-free at **1-800-453-4347**. **TTY users may call 711.** The Participating Behavioral Health Providers/Practitioners will be responsible for any additional **Prior Authorization**.

- Acute Inpatient mental health Services will be Covered when certified by PHP or PHP'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 PHP's Behavioral Health Department. 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 the PHP Behavioral Health Department.
- Acute medical detoxification benefits are Covered under Inpatient and Outpatient Medical Services found in the **Benefits** Section, Hospital Admissions – Inpatient and Outpatient Medical Services.

**Exclusions**
In addition to the exclusions listed in the **Exclusions** Section of this Summary Plan Description (SPD), the following are **not Covered**:

- Codependency treatment;
- Counseling: sex and pastoral/spiritual 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

**Alcoholism Services and Substance Use Services**
The following benefits are applicable for Alcoholism/Substance Use Services. In all cases, treatment must be Medically Necessary in order to be Covered.

- An episode of treatment is a planned, structured, and organized program to promote an alcohol and/or Substance Use free status that may include different facilities or modalities, including Inpatient, partial hospitalization and outpatient Services.
- The following limitations apply to an episode of treatment:
    - Inpatient treatment in a Hospital or Substance Use treatment center will be Covered when certified by PHP's Behavioral Health Department
    - Partial Hospitalization can be substituted for Inpatient Alcoholism or Substance Use Services if certified by PHP. 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 outpatient Alcohol and/or Substance Use Services are defined as visits lasting three hours per visit and attended by the Member three times per week. Standard outpatient therapy visits are defined as outpatient visits lasting up to 50 minutes
- An episode of treatment will be considered complete if any one of the following occurs:
    - The Member is discharged on medical advice from Inpatient treatment, partial hospitalization and/or outpatient Services; or
    - The Member fails to materially comply with any treatment program for a period of **30 days**

- Acute Medical Detoxification Benefits are Covered under Inpatient and Outpatient Hospital Services found in the **Benefits** Section, Hospital Admissions – Inpatient and Outpatient Medical Services.

For assistance in locating a provider for inpatient Services, Members may contact the PHP Behavioral Health Department at **(505) 923-5470** or toll-free at **1-800-453-4347**. **TTY users may call 711**. The Behavioral Health Provider/Practitioner will be responsible for any additional **Prior Authorizations**.

**Exclusions**
In addition to the exclusions listed in the Summary Plan Description (SPD), the following are not Covered:

- Treatment in a halfway house;
- Residential Treatment Centers used for the treatment of any condition other than Alcoholism and/or Substance Use;
- Codependency treatment; sex, and pastoral/spiritual counseling; and
- Court-mandated treatment, or treatment that is a condition of parole or probation or in lieu of sentencing

## Outpatient Medical Services

(Services administered at a medical facility such as a Hospital or doctor's office after which the Member goes home without being admitted to the facility).

Outpatient medical Services include reasonable Hospital Services provided on an ambulatory basis, and those preventive, Medically Necessary, and diagnostic and treatment procedures that are prescribed by the Member's attending Provider, subject to the **Prior Authorization** requirements listed in the **Prior Authorization** Section, and limitations and the exclusions listed in the **Limitations and Exclusions** Section. Such Services may be provided in a Hospital, Provider'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 PHP, a medical Group, an independent practice association or other authority authorized by applicable law or authority.

- Anesthetics, oxygen, drugs, medications
- Blood, blood plasma and blood components
- Chemo and radiation therapy
- Diagnostic Services, as specified in the **Benefits** Section, 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 Substance Use detoxification
- Observation: 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 an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Providers/Practitioners written order. To transition from observation to an Inpatient admission level of care, criteria used by PHP must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

- 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
- Benefits are available for surgical treatment of morbid obesity (bariatric surgery) only when prescribed and performed by a Participating Provider and when Medically Necessary with a body mass index (BMI – weight in kilograms divided by height in meters squared) of 40 or more. **Prior Authorization** may be required

## Provider Services

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

- A licensed Provider;
- Specialist Services provided by other health 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; or
- Other authority authorized by applicable state Law

The Provider Services covered by this Section are subject to the **Prior Authorization** requirements contained in the **Prior Authorization** Section and the limitations exclusions listed in the **Limitations and Exclusion** Sections. This Plan covers consultation, healthcare Services and supplies provided by the Member's Provider including:

- Office visits provided by a qualified Provider/Practitioner. Services of a Provider for the diagnosis and treatment for mental illness or Substance Use shall be provided according to the **Benefits** Section, Mental Health and Substance Use.
- Video visits provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters.
    - PHP Video Visits utilize a nationwide network of Providers.
    - Telehealth appointments through video or telephone are with a network Provider, including some Presbyterian Medical Group Providers. They require most members to pay a normal Copayment or Cost Sharing, just like with an in-person visit.

- Online Visits are an online medical interview followed by a response from a Presbyterian Medical Group Provider.
- 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 Providers as part of continued supervision of Covered care
- Allergy Immunotherapy, including testing and sera
- Family planning/infertility Services:
    - Sterilization procedures. Reversal of voluntary sterilization is not Covered.
    - Infertility diagnosis and treatment, including drugs and injections administered in the Participating Provider's office and approved by PHP in accordance with accepted medical practice for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery. Artificial insemination is Covered for up to three inseminations. Donor sperm is not Covered. In-vitro, GIFT and ZIFT fertilization are not Covered. Reversal of voluntary sterilization is not Covered. Infertility diagnosis and treatment, including drugs and injections are not Covered if received from non-Participating Providers/Practitioners.
- Subsequent medical opinions:
    - ***For Copay Plan, In-network*****,** the office visit Copayment will not apply if PHP requires a subsequent medical opinion to evaluate the medical appropriateness of a diagnosis or service. The office visit Copayment will apply when the Member or the Provider/Practitioner requests a subsequent medical opinion.
    - ***For Copay Plan, Out-of-network,*** the office visit Deductible and Coinsurance will not apply if PHP requires a subsequent medical opinion to evaluate the medical appropriateness of a diagnosis or service. The office visit Deductible and Coinsurance will apply when the Member or the Provider/Practitioner requests the subsequent medical opinion.

## Prescription Drug Benefit (Outpatient) – Express Scripts

Prescription Drugs are administered by Express Scripts**.** Call **Express Scripts** at **1-866-217-3774**.

## 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. The Member's Provider must prescribe Reconstructive Surgery, and **Prior Authorization** from PHP 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.

## Rehabilitation and Therapy

**Cardiac Rehabilitation Services.**
Coverage is provided for 12 sessions of progressive exercises and continuous electrocardiogram (ECG) monitoring and up to 24 sessions of progressive exercises and intermittent ECG monitoring, per Member per Calendar Year.

**Pulmonary Rehabilitation Services.**
Coverage is provided for 24 sessions of progressive exercises and monitoring of pulmonary functions per Member per Calendar Year.

**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 Members in restoring functions that were lost or diminished due to a specific episode of illness or injury (for example, stroke, motor vehicle accident, or heart attack). Coverage is subject to the following limitations:

- Outpatient physical therapy is limited to up to 80 visits per Annual Calendar Year if Medically Necessary.
- Outpatient occupational therapy is limited to up to 80 visits per Annual Calendar Year if Medically Necessary.
    - Outpatient physical therapy and outpatient occupational therapy are both subject to their respective visits limitation being combined between In-network and Out-of-network Services.
    - Treatment goals must be established at the initial visit. These goals must define the expected Significant Improvement.
    - A licensed physical or occupational therapist must provide and/or direct therapy treatments. Treatments by a Provider or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist.
    - **Treatments delivered by athletic trainers are not Covered**.
- Long-Term Rehabilitation Services are **not Covered**. Therapies are considered long-term when:
    - The Member has reached maximum rehabilitation potential;
    - The Member has reached a point where Significant Improvement is unlikely to occur; or
- Long-Term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief.

- **Long-Term therapy of treatment of chronic conditions is not Covered**. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down's Syndrome, Cerebral Palsy, Autism and developmental delays not associated with a defined event of illness or injury.
- **Vocational Rehabilitation Services are not Covered**.
- **Athletic trainers are not Covered**.
- Outpatient Speech and Hearing Therapy. Speech therapy means language, dysphagia (difficulty swallowing) ***and*** hearing therapy. Speech therapy is Covered when provided by a licensed or certified speech therapist **subject to the following limitations**:
    - The Member's Provider must determine in advance, in consultation with PHP, that speech and hearing therapy can be expected to result in Significant Improvement in the Member's condition within 80 visits per Calendar Year.
    - Speech and hearing therapy may require **Prior Authorization** from PHP.
        - Certified by PHP;
        - The Member's Provider in consultation with PHP certifies that the speech therapy is Medically Necessary and will result in Significant Improvement. For purposes of authorizing speech and hearing therapy beyond the initial 80 visits per Calendar Year, the determination of Significant Improvement will be established if the Member has met all therapy goals for the preceding 80 visits as documented in the therapy record.
- **In no event will speech and hearing therapy be Covered beyond 80 visits maximum per Calendar Year for Outpatient speech and hearing therapy.** Any Outpatient speech and hearing therapy beyond 80 visits per Calendar Year or Inpatient speech therapy six consecutive months is defined as **Long-Term Therapy, which is not Covered** under any circumstances.
- Speech therapy will be Covered **only** for the following conditions:
    - 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 non-verbal 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.
- Therapy for stuttering is not Covered.

- Hearing aid evaluations are not Covered except for school-aged children under 18 years old (or under 21 years of age if still attending high school).
- No additional benefits are available for speech and hearing therapy.
- 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 visits limitation requirements of the outpatient therapies outlined above and are not combined with outpatient Services when calculating the total accumulated benefit usage.

## Skilled Nursing Facility

Room and board and other necessary Services furnished by a Skilled Nursing facility will be provided when a Member requires skilled nursing care of the type provided by the facility. Admission to the facility must be arranged and certified by PHP and by the Member's Provider. Admission must be appropriate for the Medically Necessary care and rehabilitation of the Member. Skilled Nursing Facility care is provided for up to **60 days** per Member, per Calendar Year. This visit limitation is combined between in-network and out-of-network Services. **Custodial or Domiciliary Care is not Covered**.

## Smoking Cessation

Coverage is provided for Diagnostic Services, Smoking Cessation Counseling and certain pharmacotherapy Services. Medical Services are provided by licensed healthcare professionals with specific training in managing the Member's Smoking Cessation Program. The program is described as follows:

- Individual counseling at a Participating Provider/Practitioner's office is Covered under the medical benefit. The non-specialist or specialist Copayment applies. There is no limit to the number of visits that are Covered. **Non-Participating Providers/Practitioners are not Covered.**
- Group Counseling, including classes or a telephone "quitline," are Covered through a Participating Provider/Practitioner. No Copayment will apply, and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer Group-counseling Services at no charge. Members may want to utilize these Services. (Contact the Presbyterian Customer Service Center for a list of programs.)
- Pharmacotherapy Benefits are limited to:
    - Prescription Drugs are administered by **Express Scripts**. Call **Express Scripts at 1-866-217-3774**
    - Two 90-day courses of treatment per Calendar Year
    - Refer to "Covered Medications" in your *Summary of Benefits* for Coinsurance amounts

**Exclusions:**
Hypnotherapy - the use of therapeutic techniques or principles in conjunction with hypnosis. Hypnosis is the process by which a trained therapist helps the patient become so relaxed that the Member may be able to accept new ways of thinking or reacting to behaviors which the patient wishes to change.

## 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 valves, are not Covered.
- All transplants must meet Medical Necessity criteria as determined by PHP and be certified by PHP.
- All Organ transplants must be deemed Medically Necessary by the Member's Provider. Transplant Services shall be performed at a site approved by PHP.
- 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 out of state and in-state, up to a maximum of $150 per day for both the transplant recipient and companion, combined. All benefits for transportation, lodging and meals are limited to a lifetime maximum of $10,000. This benefit does not include transportation costs for deceased Members.
- If there is a living donor that requires surgery to make an Organ available for a Covered transplant for a Member, 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. This Plan 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 received from non-Participating Providers/Practitioners are not Covered.

## Women's Healthcare

The following Services are available for female Members ages 13 or over.

- **Obstetrical/gynecological care** includes annual exams, care related to pregnancy, miscarriage, and other obstetrical/gynecological Services.
    - You do not need prior authorization from City of Rio Rancho or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. However, the healthcare professional may be required to comply with certain procedures, including obtaining prior authorization for certain Services, following a pre-approved treatment plan, or procedures for making

referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the Presbyterian Customer Service Center at **(505) 923-5208** or **1-877-752-4164**.

- **Maternity and newborn care**
  - Maternity Coverage is available to a mother and her newborn (if enrolled) under this Agreement 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.
  - 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 Member's attending Provider. In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her attending Provider. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, including, but not limited to, the criterion that family members or other support person(s) will be available to the mother for the first few days following early discharge.
  - **Newborns of a Subscriber or a Subscriber's spouse or Domestic Partner** will be Covered from the moment of birth when enrolled if the child's signed and completed enrollment application form is submitted and received by City of Rio Rancho within **30 days** from the date of birth. Otherwise, the newborn cannot be enrolled for PHP Coverage until the next Annual Group Enrollment Period.
  - A newborn of a Member's Dependent child cannot be enrolled unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by the court as the newborn's legal guardian.
  - Neonatal care is available for the newborn of a Subscriber or Subscriber's spouse 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.
  - A separate Inpatient Copayment for your newborn applies only when the infant's Inpatient stay exceeds the mother's date of discharge. Additional services above and beyond routine newborn care are not subject to an additional Copayment if the infant is discharged on the same day or before the mother is discharged from the Hospital.
  - 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, 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 **Benefits** Section, 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 but 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 an infant.
    - For the purpose of Coverage under this Plan, the only allowable sites of delivery are a Hospital or a licensed birthing center. Elective Home Births and any prenatal or postpartum Services connected with Elective Home Births are not Covered. Elective Home Birth means a birth that was planned or intended by the Member or Provider/Practitioner to occur in the home.
    - The combined fees of the Midwife and any attending or supervising Provider(s), for all service provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Provider had the Midwife 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 sixteen and twenty weeks of pregnancy, to screen for certain abnormalities in the fetus), visits to an Obstetrician, Certified nurse-midwife, or licensed Midwife, childbirth in a Hospital or in a licensed birthing center. Elective Home Births are not Covered.
- Cytologic screening (Pap smear), HPV screenings, HPV Vaccine coverage for females in accordance with the guidelines established by The Advisory Committee on Immunization Practices (ACIP) and mammography coverage is described in the **Benefits** Section, Clinical Preventive Services.
- Mastectomy, Prosthetic Devices and Reconstructive Surgery. 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, Copayment and/or Coinsurance consistent with those imposed on other benefits. Please refer to your *Summary of 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 a 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 Members with external breast prostheses. All care must be provided by or under the direction of the Member's Provider and with appropriate **Prior Authorization** from PHP.
- 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 Member's Provider/Practitioner in consultation with PHP.

## Prior Authorization

**What is Required?**
Certain Services and supplies are Covered Benefits must be certified. **Prior Authorization** means the process whereby Presbyterian Health Plan (PHP) or PHP's delegated Provider/Practitioner contractor reviews and approves in advance the provision of certain Covered Benefits to Members before those Services are rendered.

If Services provided by Participating Providers/Practitioners require a **Prior Authorization,** then it is the responsibility of the Participating Providers/Practitioners to obtain the **Prior Authorization**.

**If Services provided by non-Participating Providers/Practitioners require Prior Authorization and Prior Authorization was not obtained, the Member will be subject to a 20 percent penalty**. **The Member is responsible for ensuring that non-Participating Providers/Practitioners have obtained Prior Authorization when a Prior Authorization is required. Services rendered beyond the scope of the Prior Authorization are not Covered**.

**Who is Responsible?**
**Prior Authorization** of Services or supplies rendered by Participating Providers/Practitioners is the responsibility of the Participating Provider/Practitioner. Members will not be liable for charges resulting from the failure of the Participating Provider/Practitioner to obtain such required **Prior Authorization**. All **Prior Authorizations** are provided by the PHP medical director or the medical director's designee.

**When accessing out-of-network benefits (including those received from** National Network Provider **Providers)**, **you are responsible for ensuring Prior Authorization from PHP or PHP's designee has been obtained prior to the Out-of-network Services being performed**. **If Prior Authorization is not obtained when required, the Member will be subject to a 20 percent penalty**.

**What Services and Supplies Require Prior Authorization?**
The **Prior Authorization** process and requirements are regularly reviewed and updated based on various factors, including medical trends, Provider participation, and federal regulations, and PHP's own policies and procedures. Your Participating Provider/Practitioner will know when **Prior Authorization** is necessary. **It is your responsibility to request Prior Authorization for the following Services if they are to be received from a non-Participating Provider/Practitioner**. The following Services and supplies require **Prior Authorization**:

- Blood glucose specialized monitors/meters, including those for the legally blind;
- Bone growth stimulators;
- Clinical Trials (Investigational/Experimental) as specified in the **Benefits** Section, Clinical Trials;
- Computed Axial Tomography (CAT) Scans;
- Diabetic supplies purchased through a Durable Medical Equipment supplier;

- Durable Medical Equipment, orthotic and prosthetic devices;
- Foot Orthotics, as specified in the **Benefits** Section, Durable Medical Equipment;
- Home health Services/home health intravenous drugs;
- Home uterine monitoring;
- Hospice care;
- Hospital admissions, Inpatient non-emergent;
- Infertility Services;
- Injectable drugs (includes Specialty Medications and home health intravenous drugs) except as noted in the **Benefits** Section;
- Insulin pumps;
- Magnetic Resonance Imaging (MRI) tests;
- Medical detoxification;
- Inpatient Mental Health Services;
- Observation more than **24 hours**;
- Organ transplants;
- Positron Emission Tomography (PET) scans;
- Prosthetics;
- Reconstructive and potentially cosmetic procedures;
- Skilled Nursing Facility care;
- Speech/Hearing therapy;
- Special Inpatient Services, for example, private room and board and special duty nursing;
- Inpatient Substance Use Services; and
- Transplants

If a request for a **Prior Authorization** is made and not approved, PHP will notify the Member and the requesting Provider of the adverse determination by telephone (or as required by the medical exigencies of the case) within **24 hours** after making the determination. PHP will also notify the Member and Provider of the adverse determination by written or electronic communication sent within one working day of a telephone notice.

Please see the **Grievance** Section for information regarding the request for internal review of any adverse determinations made by PHP.

## 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.

Essential Benefits-Section 1302 (b) of the Affordable Care Act defines essential health benefits to include at least the following general categories and the items and Services covered within the categories: ambulatory patient Services; emergency service; hospitalization; maternity and newborn care; mental health and substance use disorder Services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative service and devices; laboratory Services; preventive and wellness Services and chronic disease management; and pediatric Services, including oral and vision care.

## Limitations

**Choice of Provider/Practitioner**. If more than one type of Provider/Practitioner is qualified to furnish a particular item or Covered Benefit, Presbyterian Health Plan (PHP) may select the type of Provider/Practitioner to be used.

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

**Major Disasters**. In the event of any major disaster, epidemic or other circumstances beyond PHP’s control, PHP shall render or attempt to arrange Covered Benefits with Participating 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 PHP’s control, and if PHP 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 terrorism, riot, civil insurrection, disability of a significant part of a Hospital, PHP personnel or Participating Providers/Practitioners or similar causes. This provision does not impose any limitation on the availability of Coverage for Services provided by non-Participating Providers/Practitioners.

**Organ Transplants**. Organ transplants are limited to those procedures and benefits described in the **Benefits** Section, Transplants.

**Prior Authorization.** Availability of certain Services and supplies is subject to **Prior Authorization** as specified in the **Prior Authorization** Section.

**Benefit Limitations**. Some Services may be subject to dollar amount and/or visit limitations or may not be available from non-Participating providers. Refer to your *Summary of Benefits* and the **Benefits** Sections for these limitations. All Services are subject to the requirements identified in the **Benefits** Section, the **Prior Authorization** requirements listed in the **Prior Authorization** Section, the plan limitations listed in this Section and the exclusions listed in the **Exclusions** Section.

**Liability.** City of Rio Rancho is not liable for any damages associated with treatment provided under this Plan.

## Exclusions

Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice.

**Elective termination of pregnancy** after the 24th week of pregnancy.

**Alternative/complementary therapies**, except as specified in the Summary Plan Description (SPD).

**Artificial aids,** including speech synthesis devices except items identified in the Summary Plan Description (SPD).

**Athletic** trainers are excluded.

**Autopsies and/or transportation costs** for deceased Members.

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

Exclusions related to **Behavioral Health Services**:

- **Halfway houses**
- **Residential Treatment Centers** unless for the treatment of Alcoholism and/or Substance Use rehabilitation
- **Codependency treatment**
- **Counseling**: Sex, and pastoral/spiritual 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. Refer to the Summary Plan Description (SPD) for more information

**Benefits and Services not specified as Covered**.

**Biofeedback**, except as specified in the Summary Plan Description (SPD).

Exclusions relating to **Clinical Trials**:

- Any Clinical Trials that do not meet the requirements indicated in the **Benefits** Section, Clinical Trials.
- Costs of the Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.
- Services from non-Participating Providers/Practitioners, unless Services from a Participating Provider/Practitioner are not available.
- The cost of a non-FDA-approved Investigational drug, device or procedure.
- The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Clinical Trial.
- Cost associated with managing the research that is associated with the Clinical Trial.
- Costs that would not be Covered if non-Investigational treatments were provided.
- Costs of tests that are necessary for the research of the Clinical Trial.
- Costs paid or not charged for by the Clinical Trial Providers.

**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 Member is legally entitled and for which facilities are reasonably available to the Member.

**Charges that are determined to be unreasonable by PHP**.

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

**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 4 by 4's), and ace bandages, except when provided in a Hospital or Provider's office or by a home health professional.

**Convenience items**: An appliance device, object or service that is for comfort and ease and is not primarily medical in nature. Examples include but are not limited to shower stools/chairs/seats, bath grab bars, showerheads, vaporizers, wheelchair/walker/stroller accessories such as baskets, trays, seats or shades.

**Corrective eyeglasses** or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, except as identified in the **Benefits** Section, Durable Medical Equipment.

**Cosmetic Surgery**. 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 for truncal veins), and nasal rhinoplasty.

**Cosmetic surgery, treatments**, devices, orthotics, and medications, including treatment of hair loss.

**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 or Domiciliary Care**.

Exclusions relating to **Dental Services**:

- Dental care and dental X-rays, except as provided in the Summary Plan Description (SPD).
- Dental implants.
- 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.

Exclusions relating to **Durable Medical Equipment**:

- Duplicate Durable Medical Equipment items (i.e., for home and office).
- Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs and other conditions (as determined by PHP), 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.
- Custom-fabricated Orthotics/Orthosis are not Covered except for knee-ankle-foot Orthosis (AFO and/or KAFO) except for Members up to 8 years old.
- Upgraded or deluxe Durable Medical Equipment.
- Additional wheelchairs, if the Member 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 for convenience.
- Repair and replacement of items under the manufacturer or supplier's warranty.

**Elastic Support hose.**

**Elective Home Birth** and any prenatal or postpartum Services connected with an Elective Home Birth.

**Exercise equipment** and videos, personal trainers, club memberships and weight reduction programs.

Drugs, medicines, treatments, procedures, or devices that PHP determines are **Experimental or Investigational**. This means that one or more of the following is true:

- The drug, medicine or device cannot be marketed lawfully without the approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the drug, medicine or device is furnished;
- 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, except as specified in the Benefits Section, Clinical Trials, or 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; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.
- 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.

**Extracorporeal shock wave therapy** involving the musculoskeletal system.

Exclusions relating to **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'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, and
- 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.

**Hearing aids** and the evaluation for the fitting of hearing aids **except for school-aged children under 18 years old (or under 21 years of age if still attending high school)**.

Costs for **extended warranties** and **premiums for other insurance coverage**.

**Hospice 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 or spiritual counseling

**Hypnotherapy** except as part of anesthesia preparation or chronic pain management.

The following **Infertility Services/Artificial conception** Services are not covered: donor sperm, In-vitro, GIFT and ZIFT fertilization.

**Malocclusion treatment**, if part of routine dental care and orthodontics.

**Massage Therapy** unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program.

Services of a lay **Midwife** or an unlicensed Midwife.

**A newborn of a Member's Dependent child**, unless the Subscriber has legally adopted the newborn, or unless the court has appointed the Subscriber as the newborn's legal guardian.

**Non-human Organ transplants** except for porcine (pig) heart valve.

The medical and Hospital Services of an **Organ transplant donor** when the recipient of an Organ transplant is not a Member or when the transplant procedure is not Covered.

Services, other than emergent or urgent in nature, received **outside of the United States**.

**Personal or comfort items**, Services or treatments such as, but not limited to, aromatherapy, pet therapy, homemaker and housekeeping Services.

**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 purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment.

**Prescription Drugs.** Prescription Drugs **are administered by Express Scripts**. Call Express Scripts at **1-866-217-3774**.

**Private duty nursing**.

**Reversals of voluntary sterilization**.
**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 peripheral neuropathies.

To the extent determined by law, **Services for which the Member 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 Member or Dependent.

**Services requiring Prior Authorization** when **Prior Authorization** was not obtained will be subject to a 20 percent penalty.

**Sex transformation** surgery and drugs related to sex transformation.

Treatment for **sexual dysfunction**, including counseling, and clinics, except for penile prosthesis as provided in the Summary Plan Description (SPD).

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

**Transportation costs** for deceased Members.

**Travel and lodging expenses** except as provided in the **Benefits** Section, Transplants.

Exclusions relating to **Vision Services**:

- Eye movement therapy
- 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 **Benefits** Section Durable Medical Equipment and Clinical Preventive Services
- Visual training

**Vocational Rehabilitation** Services and Long-term Rehabilitation Services.

Treatments for the purpose of **weight reduction** or control except for Medically Necessary treatment for morbid obesity. Bariatric surgery is not covered when provided as an out-of-network service.

Treatment of **work-related accidents or injuries** or occupational illness or disease if the Member is required to be Covered under Workers' Compensation insurance, whether or not such Coverage actually exists.

**War:** Claims which arise out of or are caused or contributed to by war or an act of war. **War** means declared or undeclared war, whether civil or international and any substantial armed conflict between organized forces of a military nature.

**Felony:** Claims for any period caused or contributed to by a Participant committing or attempting to commit an assault or felony, participating in an illegal occupation, actively participating in a violent disorder or not, or operating any vehicle while under the influence of any intoxicant. Actively participating does not include being at the scene of a violent disorder or not while performing his or her official duties.

## Continuation of Coverage

**Members whose Coverage would otherwise terminate because of a loss of eligibility may be entitled to continue their Coverage under one of the following options:**

Most employer Groups with 20 or more employees are required to offer Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. If a Member is entitled to COBRA Coverage, the Member may continue his or her Coverage as a Member of the Group under this Agreement for the period of time allowed under COBRA unless and until:

- City of Rio Rancho stops offering membership in this Plan to its employees;
- The Member terminates his or her Coverage;
- The Member's Coverage under this Agreement is terminated for Good Cause;
- The Member fails to make a timely election for COBRA Coverage;
- The Member fails to make timely payments for his or her COBRA Coverage;
- The Member becomes Covered under another Group health plan and is not subject to a Pre-existing Condition clause;
- The Member becomes entitled to Medicare benefits; or
- The Member no longer meets City of Rio Rancho eligibility requirements;
- Domestic Partners and their dependents are not entitled to COBRA continuation benefits

**Extension of Benefits for the Totally Disabled**
In the event a Member is Totally Disabled on the date their Group Coverage terminates, healthcare Coverage may be continued (for the disabling condition only) for up to 12 consecutive months. **To claim an extension of benefits, you must notify City of Rio Rancho within 30-days of the Group's Coverage termination date and provide evidence of your Total Disability**.

For purposes of this Section, Totally Disabled means that the individual is prevented, solely because of injury or disease, from performing their regular or customary occupational duties or is incapable of doing most of the normal activities and tasks for that person's age and family status. In order to qualify for benefits under this extension, a Member must have been Totally Disabled on the date of the Group's termination, incur an expense **directly resulting** from that particular disability, and such expense would have been a Covered service before termination.

**Transition of Care**

- If a Member's healthcare Provider/Practitioner leaves the PHP network, the Member may continue an ongoing course of treatment with that Provider/Practitioner for a transitional period of no less than **30 days**.
- For a Member who is in the third trimester of pregnancy when her Provider/Practitioner leaves the network, the transitional period will include postpartum care directly related to the delivery.

- This “transitional period rule” does not apply for any Provider/Practitioner who has been terminated from the network for reasons related to medical competence or professional misbehavior.
- For transitional periods exceeding **30 days**, PHP will Certify continued care only if the healthcare provider agrees to:
    - Accept reimbursement from PHP at the rates applicable before the Provider/Practitioner left the network;
    - Adhere to PHP’s quality standards and provide PHP with necessary medical information related to such care; and
    - Otherwise, adhere to PHP’s policies and procedures including, but not limited to procedures regarding **Prior Authorization** and treatment planning approved by PHP.
- If upon the effective date of enrollment, a Member’s healthcare Provider/Practitioner is not a Member of the PHP Provider/Practitioner network; the Member may continue an ongoing course of treatment with that Provider/Practitioner as outlined in the “transitional period rule” described in items one to four above.

# Claims

**Notice of Claim**
Written notice of claim must be given to Presbyterian Health Plan (PHP) within **20 days** after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

**Claim Forms**
Upon receipt of a notice of claim, PHP will furnish the forms needed for filing proof of loss. Forms will be furnished within **15 days** after PHP's receipt of such notice.

**Participating Providers/Practitioners**
PHP pays Participating Providers/Practitioners directly for Covered Services provided to Members. A Member should not be required to pay sums to any Participating Provider/Practitioner except for required Deductible, Copayment and Coinsurance. Members will be responsible for payment of charges for missed appointments or appointments canceled without adequate notice. If a Member is asked by a Participating Provider to make any Deductible, Copayment or Coinsurance in addition to the Deductible, Copayment and Coinsurance specified in this Agreement, the Member should consult the Presbyterian Customer Service Center before making any such additional Deductible, Copayment or Coinsurance. A Member shall not be liable to a Participating Provider/Practitioner for any sums owed to the Provider/Practitioner by PHP.

**Procedure for Reimbursement**
If a charge is made to a Member for Covered Benefits, written proof of such charge must be furnished to PHP within **90 days** from the date of service for Participating Providers/Practitioners and within one year from the date of service for non-Participating Providers/Practitioners in order for reimbursement to be made. Members relying on a non-Participating provider to file on their behalf are responsible for ensuring claims have been submitted within one year from the date of service. Any such charge shall be paid only upon receipt of written proof satisfactory to PHP of the occurrence, character and extent of the event and Services for which claim is made.

If you need a claim form, please contact the Presbyterian Customer Service Center. Claim forms are also available on our website at **www.phs.org**. Please submit your completed claim form to:

**Presbyterian Health Plan**
**Attn: Claims**
**P.O. Box 27489**
**Albuquerque, NM 87125-7489**

**Services Received 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 **Benefits** Section of this Summary Plan Description (SPD). Members 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.

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

**War**
Claims which arise out of or are caused or contributed to by war or an act of war. **War** means declared or undeclared war, whether civil or international and any substantial armed conflict between organized forces of a military nature.

**Felony**
Claims for any period caused or contributed to by a Participant committing or attempting to commit an assault or felony, participating in an illegal occupation, actively participating in a violent disorder or not, or operating any vehicle while under the influence of any intoxicant. Actively participating does not include being at the scenes of a violent disorder or not while performing his or her official duties.

# Effects of Other Coverage

## Coordination of Benefits

If a Member is also Covered under any other health benefit plan, other public or private group programs, or any other health insurance policy, the benefits provided or payable hereunder shall be reduced to the extent that benefits are available to the Member 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 Agreement and any other plan covering a Member, not on COBRA continuation on whose behalf a claim is made are as follows:

- Employee/Dependent Rule
    - The plan which covers the Member as an employee pays first; and
    - The plan, which covers the Member 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; and
        - The plan of the parent not having physical custody of the child pays third.
- Active/Inactive.
    - The plan which covers the Member as an active employee (or Dependent of an active employee) pays first; and
    - The plan which covers the Member 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 Member who is the Contract holder under more than one group health insurance policy, then the plan that has Covered the Member 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 a., b., c., d., or e., the plan that has no provision regarding coordination of benefits will pay first.
- If a Member 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 Member's own home, the Member shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are Covered by their motor vehicle or home owners' insurance policy. If such benefits have been provided by the Plan, this Plan shall have the right to recover any benefits provided from the motor vehicle or homeowner's insurer or the Member to the extent that they are available under the motor vehicle or homeowners' insurance policy.

- In no event shall the benefits received under this Agreement and all other plans combined exceed the total reasonable, actual expenses for the Services provided under this Agreement.
- For purposes of coordination of benefits, PHP:
    - May release, request, or obtain claim information from any individual or organization. In addition, any Member claiming benefits from PHP shall furnish PHP with any information which it may require; and
    - Has the right, if overpayment is made by PHP because of the Member'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; and
    - Will not be obligated to pay for non-Covered Services or Covered Benefits not obtained in compliance with PHP's policies and procedures
- Members who are on COBRA continuation and are also Covered by another group plan shall receive City of Rio Rancho benefits to the extent that City of Rio Rancho is secondary payor of all eligible charges, subject to the terms, conditions and limitation of this Agreement.

## Effect of Medicare on Benefits

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

## Effect of Medicaid on Benefits

Benefits payable on behalf of a Member who is qualified for Medicaid will be paid to the Plan 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; and
- The payment for the Services in question has been made by the state Human Services Department to the Medicaid Provider/Practitioner

## Subrogation

The benefits under this Agreement will be available to a Member who is injured by the act or omission of another person, firm, operation or entity. If a Member receives benefits under this Agreement for treatment of such injuries, the Plan will be subrogated to the rights of the Member or the Personal Representative of a deceased Member, or Dependent Member, to the extent of all

such payments made by the Plan for such benefits. This means that if the Plan provides or pays benefits, a Member 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 Member 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, the Plan's right of subrogation includes but is not limited to the right to be repaid when a Member recovers money for personal injury sustained in a car accident. The subrogation right applies whether the Member recovers directly from the wrongdoer or from the wrongdoer's insurer, or from the Member's uninsured motorist insurance Coverage. The Member agrees to sign and deliver to the Plan such documents and papers as may be necessary to protect the Plan's subrogation right. The Member also agrees to keep the Plan advised of:

- Any claims or lawsuits made against any person, firm or entity responsible for any injuries for which the Plan has paid benefits; or
- 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 the Plan is a violation of this Agreement. In the event a Member fails to cooperate with the Plan 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 Member.
- When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both the Member and the Plan, the Plan will, upon request by the Member or the Member'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

# Grievance Procedures

**Appeals Procedures**
PHP will administer Level I and Level II appeals on behalf of the Employer according to the procedures set forth below. These procedures apply to appeals of adverse benefit determinations based on medical necessity, appropriateness, healthcare setting level of care, effectiveness of a covered benefit and/or rescission of coverage in the event of fraud or intentional misrepresentation of material fact. **Note:** PHP 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 **Grievance** section of the SPD include the Employee and/or covered Dependent(s)) must submit a request for an appeal to PHP within **180 days** of receipt of a notice of denial of items or Services under the Plan. The Participant must tell PHP the reason why the denial should be overturned and include any information supporting the appeal. PHP will acknowledge to the Participant in writing within **one working day** that it has received a request for an Appeal. The acknowledgment letter will contain the name, address, and direct telephone number of an individual at PHP 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 working 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 working days**. PHP may extend the review period for a maximum of **10 working days** for pre-service requests and **20 working days** for post-service requests if PHP can: 1) show reasonable cause beyond PHP's control for the delay; 2) can show that the delay will not result in an increased medical risk to the Participant; and 3) provide a written progress report to the Participant and the related provider within the **25 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. PHP will not conduct expedited appeals for Services already provided ("post-service") to a Participant. If a Participant requests an expedited decision, a PHP 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 PHP, 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, PHP will notify the applicable Participant and then process the appeal within **15 working days**.

**Internal Review of Appeal of Adverse Determination by Medical Director Level I**
The appeal will be reviewed by a PHP 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 PHP 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, PHP will approve coverage of the Services. The applicable Participant and the applicable provider will be notified by mail or electronic means (fax, email, etc.) within **two working days** of such decision.

If the medical director decides to uphold an initial adverse determination, the applicable Participant and the applicable provider will be notified by 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, PHP will mail to the participant written notification of the decision and confirmation of the Participant's decision not to pursue the appeal within **three working days** of the medical director's decision.

If PHP is unable to contact the Participant by telephone within **72 hours** after making the decision to uphold the initial adverse determination, then PHP will notify the Participant by mail of the decision. Included in the notification will be a self-addressed stamped response letter that asks whether the Participant wants to pursue the Level II appeal by asking the Participant to check "yes" or "no" on the letter. If the Participant does not return the letter within **10 working days**, PHP will again try to contact the Participant by telephone. If the Participant does not respond to PHP's telephone calls and does not return the response letter within **20 working days** of the written notification to uphold the initial decision, PHP 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 PHP 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 PHP will conduct the appeal on behalf of the Employer according to the process set forth below.

**Internal Panel Review Committee**
An internal panel review committee will consider the appeal. The internal panel review committee will consist of PHP staff and one or more healthcare or other professionals. At least one of the healthcare professionals will have training and experience in the relevant field and practice in a specialty that would typically manage the case that is the subject under appeal or be mutually agreed upon by the Participant and PHP. 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**
PHP 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 PHP;
- 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 PHP prior to the hearing. Failure to notify may require rescheduling of the hearing within the time frame allowed to complete the appeal. If PHP 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. PHP will notify the Participant of this at least three working days before the hearing.

PHP 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 working days prior to the internal panel review, PHP will provide the participant with:

- Pertinent records;
- Treating provider's recommendation;
- The Summary Plan Description;
- 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 PHP; 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 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 timeframes previously noted. PHP 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 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; and
- For coverage determinations, identification of the Plan provision relied upon in reaching the decision; and
- 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 PHP 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 PHP, 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 PHP 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 PHP in writing within **60 days** 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.
- PHP 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 Plan will complete a preliminary review to determine if the Participant was covered under the plan at the time the Service was requested or provided; whether the adverse benefit determination relates to the Participant's failure to meet the eligibility requirements of the Plan; whether the Participant has exhausted the Plan's internal appeal process; and whether the Participant has provided all of the information and forms required to process an external review. Within **one business day** after completion of this preliminary review, the Plan will provide the Participant written notification giving any reasons for the ineligibility of the request for external review and describing the information or materials required, and the Plan will allow the Participant to perfect a request for external review within the four-month filing period or within the **48-hour** period following receipt of the notification, whichever is later.

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 general description of the reason for the request for external review;
- The dates the IRO received the assignment to conduct the external review and the date of their decision;
- 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 of investigative treatments;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision;
- A statement that judicial review may be available; and
- Current contact information, including the phone number for any ombudsman established under the PHS Act
- 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.
- 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.

**Administrative Grievance Procedures**
Participants may file a grievance if they are dissatisfied with any aspect 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, PHP will send the participant written acknowledgment of the grievance within **three working days** after receipt. The letter will contain the name, address, and direct telephone number of a PHP representative who may be contacted regarding the administrative grievance. The review of the grievance will be conducted by a PHP representative authorized to take action related to the grievance, if applicable, and will allow the participant to provide to PHP any information relevant to the grievance.

PHP will mail a written response to the participant within **15 working days** of receipt of the grievance. PHP 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 PHP 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 PHP.

PHP's response letter to the participant shall contain the name, title, and qualifications of the person conducting the initial review; a statement of the reviewer's understanding of the nature of the grievance and pertinent facts; a clear and complete explanation of the reason for the response/decision; the Plan provisions relied on in reaching the response; a statement that the initial decision will be binding unless the participant submits a request for reconsideration within **20 working days** of the receipt of the initial response; and 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, PHP will appoint a reconsideration committee consisting of PHP 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, PHP will schedule and hold a hearing within **15 working 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 PHP's expense. PHP will not unreasonably deny a request for postponement of the hearing.

**Reconsideration Committee Hearing**
PHP will notify the participant in writing of the hearing date, time, and place of the reconsideration committee hearing at least **10 working days** in advance. The notice will advise the participant of his or her rights:

- To attend the hearing;
- To present a case to the committee;
- To submit supporting material both before and at the hearing;
- To ask questions of any representative of PHP and be assisted or represented by a person of the participant's choice that may or may not be a legal representation

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

- The names, titles, and qualifications of the persons on the committee;
- The committee's statement of the issues involved in the grievance;
- A clear and complete explanation of the rationale for the decision;
- The Plan provision(s) relied on in reaching the decision;
- References to the evidence or documentation relied on in reaching the decision; and

- A statement that the initial decision will be binding unless the participant submits a request for external review by Employer

## Records

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice is effective as of July 1, 2010, and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the Plan creates or receives about you. You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, an amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160, 162 and 164 (the "Privacy Regulations"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

**How the Plan Will Use or Disclose Your Patient Health Information**
Other than these uses or disclosures discussed below, any use or disclosure of your Patient Health Information (PHI) will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition of obtaining insurance coverage and any law providing the insurer with rights to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a healthcare Provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to HHS;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations; and
- Uses and disclosures made pursuant to a valid authorization

The Plan will use and disclose PHI to the extent of and in accordance with the uses and disclosures permitted by Health Insurance Portability and Accountability Act (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to but not limited to, treatment, payment, healthcare operations, quality assurance, Utilization Review, processing of claims, and financial audits.

**The Plan's Duties with Respect to Your PHI**
The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices, and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties or the Plan or other privacy practices stated in this Notice.

**Your right to File a Complaint**
You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Compliant Official, describing when you believe the violation occurred and what you believe the violation was. You will not be retaliated against for filing a complaint.

**Contact Information**
If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI or your rights under HIPAA, you should contact the Human Resource Department at the City of Rio Rancho.

# Member Rights and Responsibilities

This information can also be found on Presbyterian's website at **www.phs.org**. 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 health insurer. Above all, your relationship with your Provider/Practitioner is essential to good health. We encourage open communication between you and your Provider/Practitioner.

## Member Rights

**All Members have a right to**:

1. Receive information about the organization, its Services, its Practitioners and Providers, and Members' rights and responsibilities.
2. Be treated with courtesy, consideration, respect, and recognition of their dignity.
3. Have their privacy respected, including the privacy of medical and financial records maintained by PHP and its healthcare Providers/Practitioners as required by law.
4. Participate with treating practitioners in making decisions about their healthcare.
5. Candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit Coverage.
6. Voice Complaints or Appeals about the care PHP provides and receives an answer to those Complaints or Appeals within a reasonable time.
7. Request and obtain information concerning PHP's policies and procedures regarding products, Services, Participating Providers/Practitioners, Appeals procedures and other information about PHP and the benefits provided.
8. Request and obtain information about any financial arrangements between PHP and its Participating Providers/Practitioners which might restrict treatment options or limit Services offered to Members.
9. Pay all required, pre-determined Deductibles, Copayments and/or Coinsurances at the time Services are rendered when such amounts are clearly specified by the Provider/Practitioner. In addition, request and obtain information regarding their financial responsibility, which may be the entire cost of Services, if they receive non-Covered Services or receive Services without a required **Prior Authorization** resulting in a 20 percent penalty.
10. Receive healthcare, with limits on Out-of-pocket expenses.
11. Be notified promptly of termination, decreases or changes in benefits or Services.
12. Refuse care, treatment, or medications after the Provider/Practitioner has explained the care, treatment or other advice and possible consequences of this decision in language that the Member understands.
13. Receive information from their treating Provider/Practitioner, in terms that they understand, including an explanation of their complete medical condition, recommended treatment, and risk of the treatment, expected results and reasonable medical alternatives irrespective of PHP's position on treatment options.
14. Have the explanation provided to next of kin, guardian, agent or surrogate if available, when the Member is unable to understand.

15. Have all explanations to the next of kin, guardian, agent or surrogate recorded in the Member's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Member or at the Member's request.
16. Have access to Services, when Medically Necessary, as determined by their treating Provider/Practitioner, in consultation with PHP, **24 hours** a day, **seven days** a week for Urgent or Emergency Health Services, and for other health Services as defined by this Agreement.
17. Have access to translator Services for Members who do not speak English as their first language, and translation Services for hearing-impaired Members for communication with PHP.
18. Receive a complete explanation of why Services or benefits are denied, an opportunity to Appeal the decision to PHP's internal review. See **Grievances** Section.
19. Receive a Certificate of Creditable Coverage when a Member's enrollment in PHP terminates.

## Member Responsibilities

**All Members must**:

1. Provide as much as possible, information that PHP and Providers/Practitioners need in order to provide Services or care to oversee the quality of such care or Services.
2. Follow the plans and instructions for care that the Member has agreed upon with their treating Provider/Practitioner. A Member may, for personal reasons, refuse to accept treatment recommended by Providers/Practitioners.
3. Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
4. Review their Summary Plan Description (SPD) and if there are questions, contact the Presbyterian Customer Service Center at **(505) 923-5208** or toll-free at **1-877-752-4164**, Monday through Friday, from 7 a.m. to 6 p.m. TTY users may call **711** or you may visit Presbyterian's website at **www.phs.org** for clarification of benefits, limitations, and exclusions outlined in this Summary Plan Description (SPD).
5. Follow PHP's policies, procedures, and instructions for obtaining Services and care.
6. Notify the City of Rio Rancho Human Resources Department within **30 days** of any change of name, address, marital status, eligible Dependents or newborns.
7. Notify PHP immediately of any loss or theft of his/her PHP Identification card.
8. Refuse to allow any other person to use his/her PHP Identification card.
9. Advise a Provider/Practitioner of Coverage with PHP at the time of Service. Members may be required to pay for Services if they do not inform their Provider/Practitioner of their PHP Coverage.
10. Pay all required pre-determined Deductibles, Coinsurances and/or Copayments at the time Services are rendered when amounts due are made clear at that time.
11. Promise that all information given to PHP in Applications for enrollment, questionnaires, forms or correspondence is true and complete.

12. Be informed of the potential consequences of providing incorrect or incomplete information to PHP, as described in the **General Information** Section of this Summary Plan Description (SPD).
13. Be responsible for obtaining **Prior Authorization** for Services provided by an Out-of-network provider (including National Network Provider providers) as described in the **Prior Authorization** Section of this Summary Plan Description (SPD).
14. Be responsible for any charges over Reasonable and Customary for Out-of-network Services.

## 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 meeting the criteria as stated in the Diagnostic and Statistical Manual IV 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 situation.

**AMBULATORY SURGICAL FACILITY** means an appropriately licensed Provider, with an organized staff of Providers 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 Providers and nursing Services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not a facility used primarily as an office or clinic for the private practice of a Provider or other professional Provider.

**APPLICATION** means the form that an employee is required to complete when enrolling for PHP coverage.

**ATTENDING PROVIDER** 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 is not the Attending Provider. A Provider employed by the Hospital is not ordinarily the Attending Provider.

**PRIOR AUTHORIZATION** means the process whereby PHP or PHP's delegated Provider contractor reviews and approves, in advance, the provision of certain Covered Services to Members before those Services are rendered. If you obtain Services from an In-network

Provider, they will request **Prior Authorizations** from PHP. If you obtain Services from a National PPO Network Provider, then it is your responsibility to obtain **Prior Authorization**. Failure to obtain **Prior Authorization** before obtaining Services may result in an additional monetary penalty or denial of benefits. If a required **Prior Authorization** is not obtained for Services rendered by an Out-of-network Provider, the Member may be responsible for the resulting charges. **Prior Authorization** is used in the management of healthcare needs; Services rendered beyond the scope of the **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.

**CALENDAR YEAR** means the period beginning January 1 and ending December 31 of the same year.

**CALENDAR YEAR OUT-OF-POCKET MAXIMUM** means a specified dollar amount of Covered Services received during a Calendar Year that is the Member's responsibility. This amount includes Copayments (except Pharmacy Copayments), Coinsurance, and Deductible for PCP and Specialist Services.

**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.

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

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

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

**COPAY/COPAYMENT** means the amount expressed as a fixed-dollar figure required to be paid by a Member in connection with Healthcare Services. Benefits payable by the Plan are reduced by the amount of the required Copayment for the covered service.

**COSMETIC SURGERY** means Surgery that is beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic. It is performed to reshape normal structures of the body in order to improve appearance and self-esteem.

**COVERED SERVICES** means Services or supplies specified in this SPD, including any supplements, endorsements, addenda, or riders, for which benefits are provided, subject to the terms, conditions, limitations, and exclusions of this SPD.

**CUSTODIAL 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.

**CUSTOM-FABRICATED ORTHOSIS** means an Orthosis that 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.

**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 Member of a covered employee's family who meets the requirements of the **Eligibility, Enrollment and Effective Dates** Section of this SPD and is actually enrolled in the Plan.

**DIAGNOSTIC SERVICES** means procedures ordered by a Provider or other professional Provider to determine a definite condition or disease.

**DURABLE MEDICAL EQUIPMENT** means equipment prescribed by a Provider 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 include items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

**EMERGENCY MEDICAL CONDITION** means a medical condition which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, 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 child; 2) Serious impairment to the bodily functions; or 3) Serious dysfunction of any bodily organ or part.

**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; and
- The improvement must be attainable outside the Investigational settings

**FAMILY COVERAGE** means coverage for the employee, the employee's spouse, and/or the employee's Dependent children.

**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); or
- Disorders of fat metabolism

**GRIEVANCE** means an oral or written complaint submitted by or on behalf of a covered person 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; or
- Matters pertaining to any aspect of the health benefits Plan

**HEALTHCARE PROFESSIONAL** means a Provider or other healthcare practitioner, 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.

**HIPAA** means Health Insurance Portability and Accountability Act.

**HOME HEALTH AGENCY** means an appropriately licensed Provider that both:

- Brings skilled nursing and other Services on an intermittent, visiting basis into the Member's home in accordance with the licensing regulations for home health agencies in New Mexico or in the locality where the Services are administered; and
- 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 program or facility providing care and support to terminally ill patients and their families.

**HOSPITAL** means a duly licensed Provider that is a short-term, acute, general Hospital that meets all of the following criteria:

- Is a duly licensed institution;
- For compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic Services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Providers;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service by or under the supervision of Registered Nurses;
- Is not, other than incidentally, a skilled nursing facility, nursing home, Custodial Care home, health resort, spa, or sanitarium; and
- Is not a place for rest, for the aged, for the treatment of mental illness, Admission, drug use, or pulmonary tuberculosis, and ordinarily does not provide Hospice or rehabilitation care, and is not a residential treatment facility.

**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; and (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 and that is not affiliated or associated with a Hospital, Provider, or Other Provider.

**INPATIENT** means a Member who has been admitted by a healthcare 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 Members 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 PHP 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 NAPRAPATHIC** means a naprapathy practitioner who is licensed by the appropriate state authority. Certification alone does not meet the licensure requirement.

**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.

**MAINTENANCE THERAPY** means treatment that does not significantly enhance or increase the patient's function or productivity.

**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 of the Social Security Act and all amendments thereto.

**MEDICAL CARE** means professional Services administered by a Provider or another professional Provider for the treatment of an illness or Accidental Injury.

**MEDICAL EMERGENCY** means an Accidental Injury or a condition that occurs suddenly and unexpectedly and is life-threatening or could result in permanent damage if not treated immediately. To be eligible for possible emergency benefits, the Member must seek treatment within **48 hours** of the Accidental Injury or onset of the condition.

**MEDICAL NECESSITY OR MEDICALLY NECESSARY** means Healthcare Services determined by a Provider, in consultation with the healthcare insurer, to be appropriate or necessary, according to any applicable generally accepted principles of good medical practice and practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols or practice guidelines developed by the healthcare insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical or Mental Health condition, illness, injury, or disease.

**MEDICARE** means the program of healthcare for the aged, end-stage renal disease (ESRD) beneficiaries and disabilities established by Title XVIII of the Social Security Act of 1965, as amended.

**MEDICARE SUPPLEMENTAL COVERAGE** means healthcare coverage that provides supplemental benefits to Medicare coverage.

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

**MENTAL DISORDER** means a behavioral or psychological syndrome that causes significant distress (a painful symptom) or disability (impairment in one or more important areas of functioning), or a significantly increased risk of suffering death, pain, or an important loss of freedom. The syndrome is considered to be a manifestation of some behavioral, psychological, or biological dysfunction in the person (and in some cases it is clearly secondary to or due to a general medical condition). The term is not applied to behavior or conflicts that arise between the person and society (e.g., political, religious, or sexual preference) unless such conflicts are clearly an outgrowth of a dysfunction within that person. In lay usage, "emotional illness" serves as a term for mental disorder, although it may imply a lesser degree of dysfunction, whereas the term "mental disorder" may be reserved for more severe disturbances.

**NEGOTIATED FEE SCHEDULE** means the contracted amount that PHP agrees to pay to In-network Providers for Hospital, professional Services, and other charges, and for which In-network Providers agree to accept as payment for Services rendered to Members.

**OUT-OF-NETWORK PROVIDER** means a duly licensed healthcare Provider, including medical facilities which has no agreement with PHP for reimbursement of Services to Members.

**OBSERVATION** means those furnished by a Hospital and practitioner on the Hospital's premises, which 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 practitioner's written order. If not formally admitted as an Inpatient, the patient initially is treated as an Outpatient. The Member does not meet Inpatient Admission criteria as identified in the PHP designated level of care criteria regardless of the length of time spent in the Hospital.

**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.

**ORTHOPEDIC APPLIANCES/ORTHOTIC DEVICE/ORTHOSIS** means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports a 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.

**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

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

**IN-NETWORK PROVIDER** means Providers, Hospitals, and other Healthcare Professionals, facilities, and suppliers that have contracted with PHP as In-network Providers.

**PHP VIDEO VISIT** means a virtual visit with a contracted provider. These visits are scheduled through the myPRES Portal.

**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** 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.

**PREFABRICATED** Orthosis means an Orthosis that 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's prescription for purchase.

**PRIOR AUTHORIZATION** means the process whereby PHP or PHP's delegated Provider contractor reviews and approves, in advance, the provision of certain Covered Services to Members before those Services are rendered. If a required **Prior Authorization** is not obtained for Services rendered by an Out-of-network Provider, the Member may be responsible for the resulting charges. Services rendered beyond the scope of the **Prior Authorization** may not be covered.

**PRIMARY CARE F (PCP)** means a duly licensed Doctor of Medicine or Osteopathy, formally selected by the Member to assume primary responsibility for his/her care.

**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, or Other Provider performing within the scope of the appropriate licensure.

**REASONABLE CHARGE OR REASONABLE AND CUSTOMARY (R&C) CHARGE** means the amount determined to be payable by PHP for Services rendered to Members by Out-of-network Providers, based upon the following criteria:

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

**REGISTERED LAY MIDWIFE** means a person licensed by the state to provide Healthcare Services in pregnancy and childbirth within the scope of New Mexico's lay midwifery regulations.

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

**REHABILITATION HOSPITA**L 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 Providers. Continuous nursing Services are provided under the supervision of a Registered Nurse.

**RESIDENTIAL TREATMENT CENTER** means a facility licensed to provide Residential Treatment (to include room and board) where the primary Services are behavioral health treatment provided under the supervision of a psychiatrist in a facility to individuals with behavioral health disorders but whose condition does not require care in an acute Hospital facility.

**RESPIRATORY THERAPIS**T means a person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

**SEMI-PRIVATE** means a two or more bed Hospital room, skilled nursing facility or other healthcare facility or program.

**SERVICE AREA** means the entire state of New Mexico.

**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.

**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 and prescribed by a Provider;
- Specifically processed or formulated to be distinct in one or more nutrients present in natural food;
- Intended for the medical and nutritional management of Members 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; and
- 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.

**SUBSTANCE USE** means impairment in social and occupational functioning resulting from the pathological and “compulsive” use of a substance. The concept is closely related to the definition

of substance dependence, which has similar symptoms of impairment by may include evidence of physiological tolerance or withdrawal. Typical symptoms of dependency include a failure to fulfill major role obligations at work, school, or home; recurrent use of the substance in situations where such use is physically hazardous; substance-related legal problems; and continued use even though it causes or exaggerates interpersonal problems.

**SUBSTANCE DEPENDENCE** or Chemical Dependence – Sometimes defined in terms of physiological dependence as evidenced by tolerance or withdrawal; at other times defined in terms of impairment in social and occupational functioning resulting from the pathological and repeated use of a substance. In the latter, tolerance and withdrawal symptoms may be present but are not essential. The behaviors and effects associated with substance dependence include taking the substance to relieve or avoid withdrawal symptoms; taking of larger amounts or using over a longer period than intended; unsuccessful efforts to cut down or control intake; interference with meeting major role obligations at work, school, or home; recurrent use in situations when it poses a physical hazard (e.g., driving, operating machinery); or substance use taking precedence over important social, occupational, or recreational activities.

**SUMMARY PLAN DESCRIPTION (SPD)** means this booklet.

**SURGERY** 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.

**TEFRA** means Federal law regarding the working aged.

**TELEMEDICINE** means the use of telecommunications and information technology to provide clinical healthcare from a distance. Telemedicine allows healthcare professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and technology in real-time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver healthcare Services to a site where the patient is located, along with the use of electronic media and health information. Telemedicine allows patients in remote locations to access medical expertise without travel.

**TERMINALLY ILL PATIENT** means a Member with a life expectancy of six months or less as certified in writing by the Attending Provider.

**TWO-PARTY COVERAGE** means coverage for the employee and his/her spouse or coverage for the employee and one Dependent child.

**URGENT CARE** means Healthcare Services provided by an Urgent Care Facility in emergencies.

**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.

**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.

## Acceptance Page

City of Rio Rancho agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the City of Rio Rancho POS Medical Plans: Copay Plan.

By:

Signed _____ _____

Date

City of Rio Rancho Manager

# Talkspace for Behavioral Health

## Mind Your Mental Health with Messaging Therapy
## A new solution for emotional wellbeing


Mental health affects every aspect of our lives. When you feel good, you are more productive and happier, and you can handle life with more ease. When your mental health is out of balance, like when you are stressed or worried, it can keep you from doing and enjoying the important things in your life. Just like you take care of your body, you need to take care of your mind. Magellan makes it easy to do that with messaging therapy from Talkspace.

### What is messaging therapy?

Messaging therapy enables you to find and communicate with a therapist anytime via your web browser or the Talkspace secure mobile app. No more having to wait months for an appointment or needing time off to visit a therapist in a busy office. With Talkspace, you can participate in therapy at a time and place that is convenient for you.

Talkspace therapists have a proven track record of using messaging therapy to help with a variety of conditions including anxiety, depression, substance abuse, panic and bipolar disorders, all of which can be debilitating if not treated. They can also help manage the unique challenges some people face, like being a single parent, a veteran or a member of the LGBT community.

### How it works

With Talkspace there are no appointments. You can send your therapist a message whenever you need to, and they will engage with you daily, five days a week. With a network of over 2,000 trained, licensed therapists, Talkspace will connect you with a dedicated therapist based on your needs, preferences, therapist availability and expertise. You can contact your therapist through unlimited text, video and audio messages.

### What's in it for you?

For some people, traditional in-person therapy can be intimidating, difficult to arrange, time consuming and expensive. For others, a lack of appointment availability or coverage in remote areas may cause access difficulties.

> *"I absolutely love the ability to text, video message, or voice message whenever I need support. The growth I have been able to accomplish in less than a year is far more than I ever was able to get from visiting a therapist in person for years on end."*
> *– Amanda, Talkspace User*

### With Talkspace you can:

- Engage with a therapist the same day that help is needed, not weeks later.
- Get matched to a therapist based on your unique needs.
- Develop a one-on-one relationship with the same therapist throughout your engagement.
- Live a happier, healthier life.

### Getting started

- Go to www.talkspace.com/php to access the program.
- Enter information about yourself.
- Fill out the section about your history and preferences.
- Select a therapist.

**Members on qualified High Deductible plans will be responsible for the cost of the services until they have met their deductible and co-insurance requirements. High Deductible members can go to talkspace.com to access the self-pay option.*

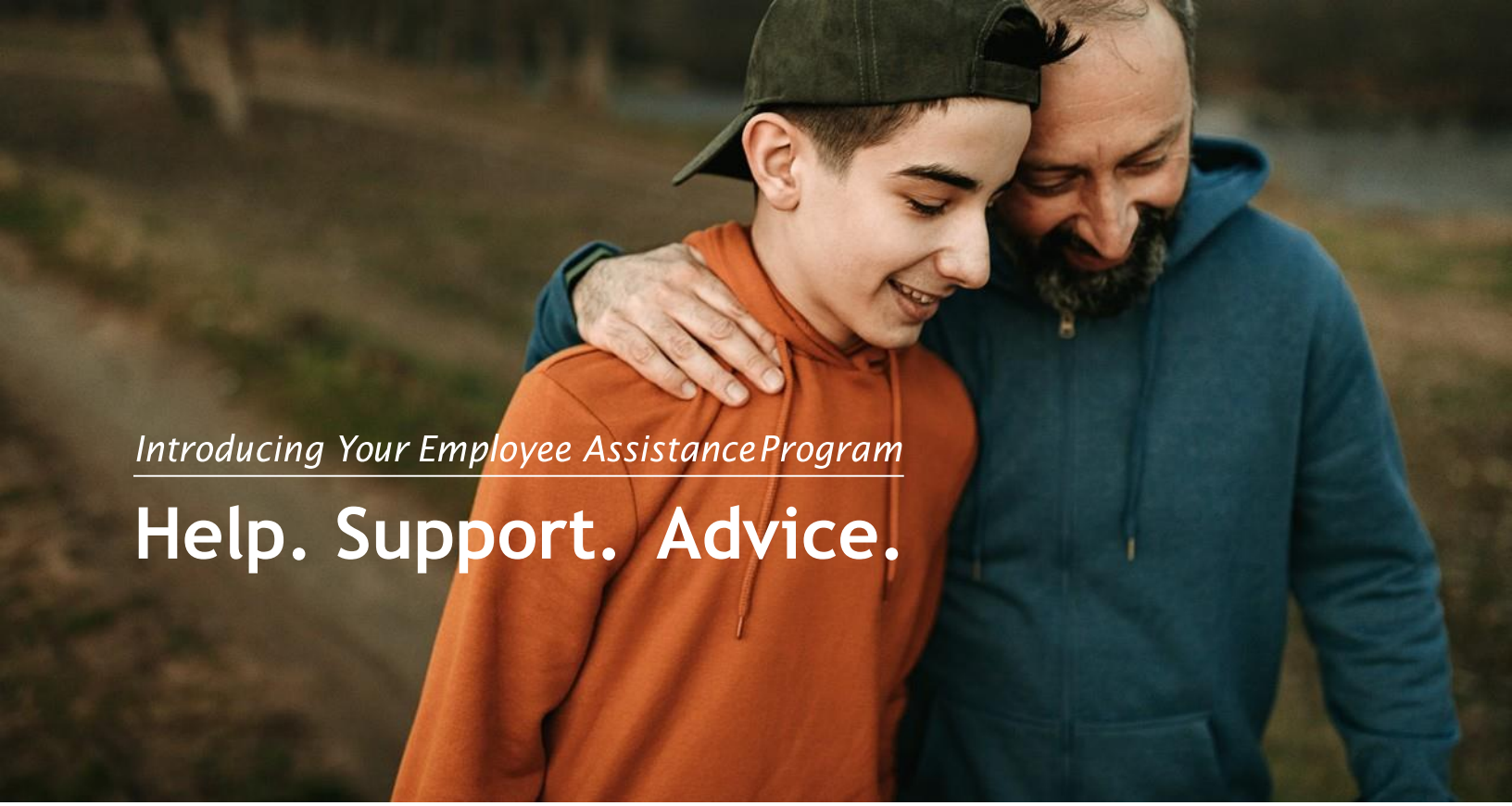
talkspace

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

MPC121809
PHP-62 0219


SERFF PBHP-131766006, PBHP-131766079, PBHP-131766082



*Introducing Your Employee Assistance Program*

# Help. Support. Advice.

If you or your loved ones face difficult situations like stress, relationship challenges, grief, loss or substance use, we're here to help. Learning how to cope with these issues can improve your overall well-being.

The Solutions Group Employee Assistance Program (EAP), a division of Presbyterian Healthcare Services offers the following services to Presbyterian Health Plan members and their household members:

- Up to six confidential counseling sessions per person, per issue, per rolling calendar year at no cost
- 24-hour telephone crisis support
- Referrals for additional support

When faced with complex personal or work-related challenges, let our EAP providers help. To schedule an appointment with an EAP counselor or for after-hours crisis support, please call <1-866-254-3555> or <(505) 254-3555>.

Services provided by:

Group The Solutions

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

MPC062438

PRESBYTERIAN | TruHearing®

1-833-731-4168 | TTY: 711

# Address your hearing loss for less.

Thanks to your Presbyterian Health Plan, you have access to tremendous savings through TruHearing®. Your 2024 hearing benefit covers up to two TruHearing *Advanced* or *Premium* hearing aids per year with low copayments.

Robert is wearing a *custom TruHearing Premium* hearing aid.

Presbyterian Health Plan*
**Exam: $45 copay[1]**

| Hearing aid | Retail price/aid | Savings/aid | **Copay per aid** |
|---|---|---|---|
| TruHearing *Premium* | $3,250 | $2,251 | **$999** |
| TruHearing *Advanced* | $2,720 | $2,021 | **$699** |

Rechargeable battery option is available on select styles for an additional $50 per hearing aid.

*TruHearing is a value added service, not insurance benefits, and may be discontinued at any time.

## Your hearing aid purchase includes

- Risk-free **60-day** trial period
- **1 year** of follow-up visits
- **80 free batteries** per non-rechargeable hearing aid
- Full **3-year manufacturer** warranty


Call TruHearing to get started.

**1-833-731-4168 | TTY: 711**

*Hours: 8am–8pm, Monday–Friday*

MPCO72310

PRESBYTERIAN | TruHearing®

**1-833-731-4168** | TTY: 711

# The right hearing aids can change your life.

Research shows that addressing hearing loss can impact your overall health and well-being, including improvements in[2]

- Mental and emotional health
- Relationship with spouse or partner
- Work performance

Jane is wearing *TruHearing Advanced RIC* hearing aids.

## The best tech for less

**Enhanced speech clarity**
to understand voices above background noise

**Bluetooth® streaming**
from your phone for convenient calls, music, movies, and more

**Fuss-free rechargeability**
up to 36 hours with portable charger options[3]

**Schedule an appointment**
**1-833-731-4168** | TTY: 711
Hours: 8am–8pm, Monday–Friday

**Learn more**
TruHearing.com/Presbyterian-HS

[1] Must be performed by a TruHearing network provider.
[2] MarkeTrak 2022.
[3] Available on select models. 36 hours of use on a single charge with 5 hours streaming.

# Expanding Access with National In-Network Care

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

With access to a robust network of more than 24,000 providers and facilities statewide, Presbyterian gives you more freedom to manage your own healthcare with local providers that you know and trust.

Your network includes Presbyterian Medical Group, Optum, New Mexico Orthopedics, TriCore Reference Laboratories, and many more.

Visit the Presbyterian Health Plan Directory online at **www.phs.org/tools-resources/member/php-directory**.

aetna®

In addition to our robust network, your plan* also gives you **in-network benefits outside of New Mexico** through our collaboration with **Aetna Signature Administrators®** Aetna's PPO network offers access to more than 1.5 million participating physicians and ancillary providers, including over 6,000 hospitals.

Simply go to **aetna.com/asa** to begin searching for a doctor using your location – ZIP, city, county, or state.

You'll be able to find specialty care, including a list of transplant facilities or pediatric congenital heart surgery facilities that are part of Aetna's Institutes of Excellence™ network.

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* Refer to your Group Subscriber Agreement to see if your plan qualifies.

**Aetna's Aexcel program-designated high-performance specialists in 12 specialties: cardiology, cardiothoracic surgery, gastroenterology, general surgery, neurology, neurosurgery, obstetrics and gynecology, orthopedics, otolaryngology, plastic surgery, urology, and vascular surgery.



MPC112347

# Keep moving with a Fitness Pass membership.

*Only $22.50 per eligible member per month.*

PRESBYTERIAN Health Plan, Inc.

As a Presbyterian Health Plan member, you and your dependents have access to more than 10,000 fitness, recreation and community centers, including:

- Defined Fitness locations in Albuquerque, Rio Rancho, Farmington and Santa Fe
- Prime Fitness network (nationwide)
- A discount at all Sports & Wellness facilities

DEFINED FITNESS

**www.defined.com**

Defined Fitness is one of New Mexico's premier health clubs, offering a wide variety of group exercise classes, supervised child care and state-of-the-art strength training and cardiovascular equipment. All locations feature an aquatic complex with an indoor pool, hot tub, dry sauna and steam room.

prime

**www.primemember.com**

The Prime Fitness network provides group exercise classes and amenities such as pools, sport courts, tracks and more. You can visit participating locations nationwide as often as you like, including select CHUZE, YMCAs, Snap Fitness, Curves® and more. When you use Prime Fitness, your fitness travels with you.

SPORTS & WELLNESS

**www.sportsandwellness.com**

Sports & Wellness is where Albuquerque has gone to find fun, friends and fitness for 25+ years. Enjoy a special discounted Presbyterian membership fee and experience five-star service and first-rate amenities at five New Mexico locations and other clubs cross the country.

## Fitness Pass program enrollment is easy. How to start:

For quick access and to learn more about Fitness Pass, go to **www.phs.org/wellness**.

- All enrolled health plan members aged 18 and older are eligible to enroll. Employees must enroll in the program for dependents to be eligible for the program.
- Once enrolled, Presbyterian will automatically debit your account or credit card each month.
- Your enrollment will last through the current calendar year, and you must reenroll each year.
- Some gyms may charge a registration or annual fee

## Your journey to a healthier you is as easy as a few clicks!

1. Visit **www.phs.org/wellness**.
2. Sign in using your myPRES credentials. Need a myPRES account? Sign up at **www.phs.org/myPRES**.
3. Select the eligible family members that would like to enroll. Remember, only enrolled members aged 18 and older are eligible for the Fitness Pass.
4. Fill out the banking information. Presbyterian accepts checking/debit accounts and most major credit cards.
5. Print/save a copy of your confirmation page. If you have any questions, please call our customer service center using the number on the back of your Member ID card and reference the confirmation number.
6. We will send your eligibility information beginning the first of the following month.
7. Visit the gym of your choice. At Defined Fitness and Sports & Wellness, you will be issued an ID card directly by the gym after you present your Presbyterian Member ID card. If you want to use Prime Fitness, visit **www.primemember.com** to obtain a Prime ID Card before visiting a gym in that network.

## Some things to keep in mind about your Fitness Pass membership

- You can use as many gyms simultaneously as you would like; there is no limit to the number of gyms you can utilize.
- Upon enrollment, your fitness pass eligibility will start on the first of the following month.
- Initial enrollment is open all year, although if you enroll you are committed through the calendar year.
- Eligible dependents must be at least 18 years of age to participate.
- Dependents living outside of New Mexico can still participate and have access to the nationwide Prime Fitness Network.
- You must be active on your Presbyterian Health Plan policy to remain eligible for the Fitness Pass.
- Fitness Pass accounts cannot be changed or cancelled voluntarily.
- If your account is cancelled for non-payment, you cannot re-enroll until the following year.
- All gym memberships through the Fitness Pass are basic memberships; upgrades may be purchased directly through the fitness center.

## Notice of Nondiscrimination and Accessibility

*Discrimination is Against the Law*

Presbyterian Healthcare Services is committed to equitable healthcare and exists to improve the health of patients, members and the communities we serve. We value diversity and inclusion and strive to treat all individuals with respect. We do not discriminate on the basis of race; color; ancestry; national origin (including limited English proficiency); citizenship; religion; sex (including pregnancy, childbirth or related medical conditions); marital status; sexual orientation; gender identity or expression; veteran status; military status; family care or medical leave status; age; physical or mental disability; medical condition; genetic information; ability to pay; or any other protected status. Presbyterian will provide reasonable accommodations and language access services for our patients, members, and workforce.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with use, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-5420, 1-855-592-7737, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated against you in another way, you can file a grievance with Presbyterian by calling 1-866-977-3021, TTY 711, fax (505) 923-5124, or **https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**Address:** U.S. Department of Health and Human Services200
Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

**Phone:** 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.



PRESBYTERIAN

# Multi-Language Interpreter Services

| | |
|---|---|
| English | ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711). |
| Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711). |
| Navajo | Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 505-923-5420, 1-855-592-7737 (TTY: 711). |
| Vietnamese | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711). |
| German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711). |
| Chinese | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420，1-855-592-7737 (TTY: 711)。 |
| Arabic | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: 505-923-5420، 1-855-592-7737 رقم هاتف الصم والبكم (TTY: 711). |
| Korean | 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오 . |
| Tagalog-Filipino | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711). |
| Japanese | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420、1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。 |
| French | ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711). |
| Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711). |
| Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711). |
| Hindi | ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें। |
| Farsi | توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید. |
| Thai | เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711). |



PRESBYTERIAN