PRESBYTERIAN

Presbyterian Health Plan

Subscriber Agreement and Guide to Your Managed Care Plan

Presbyterian Health Plan, Inc.

Individual Plans
HMO Benefit Plans

*This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or the New Mexico Health Insurance Exchange (**www.bewellnm.com**) if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.*

Underwritten by Presbyterian Health Plan

MPC022603
1/1/2026-12/31/2026
PBHP-134466123

PHP_SA_HMO_HIX_ON_2026

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

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

Phone:
(505) 923-7528 or
1-855-923-7528
TTY 711

Prior Authorization

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

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

Claims

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

Phone:
(505) 923-7528 or
1-855-923-7528

Appeals and Grievances

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

Phone:
(505) 923-7528 or
1-855-923-7528
Fax:
(505) 923-6111

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

Phone:
1-855-427-5674 or
(505) 827-4601
Fax:(505) 827-4253

Website

www.phs.org

Table of Contents

Welcome

Welcome to Presbyterian Health Plan!

Welcome and thank you for joining Presbyterian Health Plan. We are a Healthcare Insurer operated as a division of Presbyterian Healthcare Services, a locally owned New Mexico healthcare system. When we use the words "Presbyterian Health Plan," "PHP," "we," "us," and "our" in this document, we are referring to Presbyterian Health Plan. When we use the words "you" and "your," we are referring to each Member.

As part of Presbyterian Healthcare Services, the health plan represents an organization with over **100 years** of community services to New Mexicans. Our priority has been and will continue to be improving the health of individuals, families and communities. We are working to make sure that you receive quality care and service.

We are pleased to provide you with access to a comprehensive network of Physicians, Hospitals, and Outpatient medical Providers, who provide services for your Covered Benefits. We provide utilization management and quality improvement oversight programs with our commitment to Member service. We work closely with you, your Covered Dependents and your healthcare Practitioners and Providers to provide a quality, affordable healthcare plan.

Our Agreement with You

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

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

Information you will find in this Agreement includes:

- Your rights and responsibilities as a Member
- Covered Benefits available through this Plan
- How to access services from Physicians, Practitioners, Providers and Pharmacies
- Services that require **Prior Authorization**
- **Limitations and Exclusions** for certain Covered Benefits
- Coverage for your Dependents who are outside of New Mexico
- A **Glossary of Terms** used in this Agreement
- What to do when you need assistance

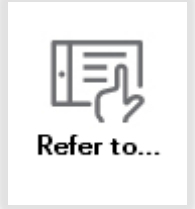
Throughout this Agreement, we ask you to refer to your *Summary of Benefits and Coverage*. The *Summary of Benefits and Coverage* is a chart that shows some specific Covered Benefits this Plan provides, the amount you may have to pay (Cost Sharing) and the Coverage **Limitations and Exclusions.**

Please take time to read this Agreement and *Summary of Benefits and Coverage*, including Benefits, **Limitations and Exclusions**. This Agreement describes your benefits and your rights and responsibilities as our Member. It also gives details on how the insured has the freedom to choose or change your PCP, what limits are placed on certain benefits, and what services are not Covered at all. Understanding how this Plan works can help you make the best use of your Covered Benefits.

You should keep this Agreement, your *Summary of Benefits and Coverage*, and any other attachments or Endorsements you may receive for future reference.

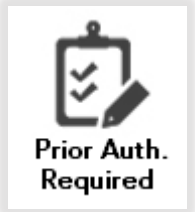
Understanding This Agreement

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

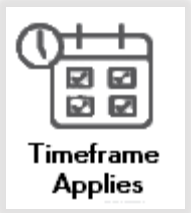


Refer To – This "Refer To" symbol will direct you to read related information in other sections of the Agreement or *Summary of Benefits and Coverage* when necessary. The Section being referenced will be bolded.

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



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



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

Important Information – This "Important Information" symbol appears when there are special instructions or important information about your Covered Benefits or your Plan that requires special attention. An example of Important Information would be how Dependent Students may receive Covered Benefits.

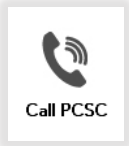
Call Presbyterian Customer Service Center – This "Call PCSC" symbol appears whenever we refer to our Presbyterian Customer Service Center or to remind you to call us for information.

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

Customer Assistance

Presbyterian Customer Service Center (PCSC)

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



Our Presbyterian Customer Service Center representatives are available Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**. You may visit our website for useful health information and services at **www.phs.org**.

Consumer Assistance Coordinator

If you need assistance completing any of our forms, if you have special needs, or if you need assistance in protecting your rights as a Member, please call our Consumer Assistance Coordinator at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**.

Written Correspondence

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

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

Member Rights and Responsibilities

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

As a Member of Presbyterian Health Plan (PHP) you have specific rights and certain responsibilities.

In accordance with New Mexico Administrative Code, we implement written policies and procedures regarding the rights and responsibilities of Covered Persons. Your rights and responsibilities are important and are explained in this Section and on our website at **www.phs.org**.

Member Rights

The Subscriber Agreement (SA) shall include a complete statement that a Member shall have the right to:

- Available and accessible services when medically necessary, **24 hours** a day, **seven days** a week for Urgent or Emergency Health Care Services, and for other Health Care Services as defined by the Agreement;
- A right to be treated with respect and recognition of their dignity and their right to privacy;
- Be provided with information concerning our policies and procedures regarding products, services, Providers, Appeals procedures and other information about Presbyterian Health Plan;
- The insured has the freedom to choose a Primary Care Practitioner within the limits of the Covered Benefits, plan network, and as provided by this rule, including the right to refuse care of specific Healthcare Professionals;
- Full freedom to choose a Primary Care Practitioner within the limits of the Covered Benefits, plan network, and as provided by this rule, including the right to refuse care of specific Healthcare Professionals; Receive from the Covered Person's Physician(s) or Provider, in terms that the Covered Person understands, an explanation of their complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of our position on treatment options; if the Covered Person is not capable of understanding the information, the explanation shall be provided to their next of kin, guardian, agent or surrogate, if available, and documented in the Covered Person's medical record;
- Receive from the Covered Person's Physician(s) or Provider, in terms that the Covered Person understands, an explanation of their complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of our position on treatment options; of the Covered Person is not capable of understanding the information, the explanation shall be provided to their next of kin,

guardian, agent or surrogate, if available, and documented in the Covered Person's medical record;

- All the rights afforded by law, rule, or regulation as a patient in a licensed Healthcare Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Covered Person understands;
- Prompt notification, as required in this rule, of termination or changes in benefits, services or Practitioner/Provider network;
- File a Complaint or Appeal with us or the Superintendent and to receive an answer to those Complaints in accordance with existing law;
- Privacy of medical and financial records maintained by us and our Healthcare Providers, in accordance with existing law;
- Know upon request of any financial arrangements or provisions between Presbyterian Health Plan and our Practitioners/Providers which may restrict referral or treatment options or limit the services offered to Covered Persons;
- Adequate access to qualified Health Professionals for the treatment of Covered Benefits near where the Covered Person lives or works within our Service Area;
- To the extent available and applicable to us, to affordable healthcare, with limits on Out-of-pocket expenses, including the right to seek care from a non-participating (Out-of-network Provider in urgent or emergent situations only, and an explanation of a Covered Person's financial responsibility when services are provided by a non-participating (Out-of-network) Provider, or provided without required **Prior Authorization**;
- An approved example of the financial responsibility incurred by a Covered Person when going Out-of-network; inclusion of the entire "billing examples" provided by the Superintendent available on the Division's website at the time of the filing of the plan will be deemed satisfaction of this requirement; any substitution for, or changes to, the Division's "billing examples" requires written approval by the Superintendent, in our Healthcare Benefit Plan that provides benefits for Out-of-network Coverage;
- Detailed information about Coverage, Maximum Benefits, and Exclusions of specific conditions, ailments or disorders, including restricted Prescription benefits, and all requirements that a Covered Person must follow for **Prior Authorization** and Utilization Review;
- A complete explanation of why care is denied, an opportunity to Appeal the decision to our internal review, the right to a secondary Appeal, and the right to request the Superintendent's assistance.
- You are allowed a **10-day** period, from the effective date of the Contract, to examine and return the Contract and have the premium refunded. If services were received during the **10-day** period, and you return the Contract to receive a refund of the premium you paid, you must pay for such services. Submissions of this type would be processed through BeWellNM.

Additional Member Rights and Responsibilities

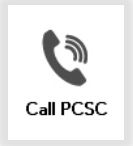
In addition to the rights and responsibilities afforded you by the state, we provide our Members with the following additional rights to:

- Receive information about our organization, our services and benefits, how to access Healthcare Services, our Practitioners and Providers, and your rights and responsibilities;
- Have a clear, private and candid discussion about appropriate or Medically Necessary treatment options for your medical condition regardless of cost or benefit Coverage;
- Participate with your Practitioner/Provider in making decisions about your healthcare;
- Refuse care, treatment, medication or a specific Practitioner/Provider, after the consequences of your decision have been explained in a language that you understand;
- Seek a second opinion for surgery from another In-network Practitioner/Provider when you need additional information regarding recommended treatment or requested care;
- Receive Healthcare Services in a non-discriminatory fashion. This means that you may not be denied Covered Services on the basis of race, color, sex, marital status, sexual preference, age, disability, cultural or educational background, religion, or national origin, economic or health status, or source of payment for care. If you have a disability, you have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act;
- PHP will not adjust premium or contribution amounts for an individual nor will we establish rules for the eligibility of any individual to enroll in coverage based on genetic information;
- Make recommendations regarding our Members' rights and responsibilities policies;
- Make your wishes known through an Advance Directive regarding healthcare decisions, such as living wills or right-to-die directives, consistent with federal and state laws and regulations;
- Choose a surrogate decision maker to assist with care decisions. If you are unable to understand your medical care, to have the healthcare explanation provided to the next of kin, guardian, agent or surrogate if available, and recorded in your medical record including, where appropriate, a medical release that you signed authorizing release of medical information.

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

- Provide, whenever possible, the information that we and your Practitioners/Providers need in order to provide services or care and to oversee the quality of those services or care;
- Follow the plans and instructions for care that you have agreed upon with your treating Practitioner/Provider. You may, for personal reasons, refuse to accept treatment recommended by Practitioners/Providers. Practitioners/Providers may regard such refusal as incompatible with continuing the Practitioner/Provider-patient relationship and as obstructing the provision of proper medical care;

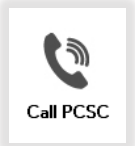
- Understand your health problems and to participate in developing mutually agreed upon treatment plans and goals;
- Review your Subscriber Agreement (SA) and if you have questions, contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**. You may visit our website at **www.phs.org** for clarification of Benefits, Limitations, and Exclusions outlined in this Subscriber Agreement. Translation/Interpretation services to understand your benefits are available, please call our Presbyterian Customer Service Center at the phone numbers listed above;



- Notify us within **31 days** of any changes of name, address, telephone number, marital status, eligible Dependents or newborns;
- Immediately notify us of any loss or theft of your PHP Identification Card;
- Refuse to allow any other person to use your PHP Identification Card;
- Advise a Practitioner/Provider of your Coverage with us at the time of service. You may be required to pay for services if you do not inform your Practitioner/Provider of our Coverage;
- Pay all required, predetermined Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time services are rendered when amounts due are made clear at that time;
- Pay for all services obtained prior to the effective date of this Agreement and subsequent to its termination or cancelation;
- Ensure that all information you give to us in Applications for enrollment, questionnaires, forms or correspondence is true and complete;
- Be informed of the potential consequences of providing us with incorrect or incomplete information as described in this Agreement;
- Obtain **Prior Authorization** as described in the **Prior Authorization** Section;
- Pay any charges over Medicare Allowable.

Consumer Advisory Board

We have established a Consumer Advisory Board, and we want your participation. This Board meets quarterly and provides Members' perspectives, as healthcare consumers, on the products and services that we offer. In addition, we share information with the Consumer Advisory Board on how well the health plan is performing. The information we receive is very valuable and helps us improve the health of individuals, families and communities. If you are interested in serving on our Consumer Advisory Board, please call our Presbyterian Customer Service Center, Monday through Friday, 7 a.m. to 6 p.m., at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**. You may also visit our website at **www.phs.org**.



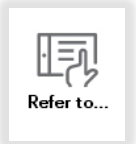
How the Plan Works

This Section explains how your Health Benefit Plan works, how to access your PCP to get Health Care Services, requirements you must follow when getting care and how to receive Covered Benefits under this Agreement.

This plan is an "HMO" (Health Maintenance Organization). People who receive Healthcare Benefits through an HMO are sometimes called "Enrollees" or "Subscribers. We strive to work closely with Subscribers, their Covered Dependents, and their healthcare Practitioners/Providers to prevent illness and provide quality, cost-effective healthcare. Because of this close working relationship, we consider our Enrollees and Subscribers to be Members of our health plan.

We require that:

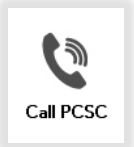
- You must physically live or work in the State of New Mexico (our Service Area) unless you are a Dependent and meet all of the terms and conditions for such Coverage as outlined in the **Eligibility, Enrollment and Effective Dates, Termination and Continuation of Coverage Section**.
- You and/or your Dependents cannot be eligible for Medicare.
    - Members have the choice of whether to enroll in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease (ESRD).
- All of your Health Care Services are provided by In-Network Contract Practitioners/Providers in our Service Area, except for Urgent and Emergency Health Care Services situations. Please refer to the Benefits Section **Accidental (Trauma) Injury / Urgent Care / Emergency Health Care Services / Observation**.
- You select a Primary Care Physician (PCP) from the Provider Directory to coordinate all of your care.
- You pay your predetermined Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time you receive Covered Services. We will reimburse the Practitioner/Provider the balance for Covered Services based upon Total Allowable Charges (some services may not require a Cost-Sharing Deductible, Coinsurance and/or Copayment). Refer to your *Summary of Benefits and Coverage* to find Covered Services subject to Cost-Sharing amounts.



To receive care under our plan, you must select an In-network PCP to manage your healthcare needs. Your PCP will be able to meet most of these needs. A list of Practitioners/Providers who serve as In-network PCPs may be found in the Provider Directory. PCPs include, but not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). As a Member of the health plan, you may choose as your PCP any doctor or Nurse Practitioner on that list.

If you do not designate a PCP on your enrollment form, we will suggest one for you.

Provider Directory



You will find our PCP close to where you live and work across the State. The Provider Directory is available on our website at **https://www2.phs.org/php_directory?insurance_plans=IFGHP** you need additional information about a Provider, you may call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**. Additionally, if you encounter old or incorrect information in the provider directory you may submit a provider directory inaccuracy report online at **https://www2.phs.org/providers** and by navigating to the identified provider's detail page and choosing the Report inaccuracies option.

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

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

Obtaining Healthcare

How to Obtain a PCP

To receive care under this plan, you and all Covered Members of your family must select an In-network PCP to manage your healthcare needs. PCPs include but not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians and Obstetricians/Gynecologists (if applicable).

Establishing a relationship with your PCP is an important part of your healthcare benefits. Remember to contact or see your PCP before you seek medical treatment. Your PCP's role extends far beyond treating you when you are ill; they understand the importance of preventing illness and promoting healthier lifestyles. Your PCP expects to manage all of your health concerns and develop an understanding of your health history.

You may want to ask relatives or friends if they have a PCP they would recommend. A Physician may not be a PCP for themselves or immediate family members. If you do not designate a PCP on your enrollment form, PHP will select one for you. You may change your PCP by contacting our Presbyterian Customer Service Center. The requested change will be effective the next business day after you call our Presbyterian Customer Service Center.

Women's Healthcare Practitioner/Provider

Any female Member **age 13** or older may select an In-network Women's healthcare Practitioner/Provider listed as a PCP in our Provider Directory as her PCP. In addition, a female Member **age 13 or older** who has not selected a Women's healthcare Practitioner/Provider as her PCP may consult with an In-network Women's healthcare Practitioner/Provider, without a referral from her PCP, for any gynecological service. No female Covered person shall be assessed a higher Cost-Sharing amount over and above the Cost Sharing required of all Covered person to be seen by any other primary care provider, for choosing a women's healthcare provider as her PCP.

Specialist Care

As our Member, you must carefully follow all procedures and conditions for obtaining care from In-network specialists and/or Out-of-network Practitioners/Providers. Out-of-network Practitioners/Providers are Covered for emergency care only or if Medically Necessary care is not reasonably available In-network. Continuity of care may also allow Out-of-network coverage for a of **30-90 days** as needed to ensure continuity of care. We no longer require a paper referral from your PCP for your visits to specialists. However, it is important to your healthcare that your PCP is included in the decisions about the specialists that you visit. Your PCP continues to be your partner for good health and is the best person to help you determine your needs for specialty care.

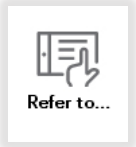
Effective communication about your medical history and treatment between your PCP and the specialists that provide care for you is very important so that the best decisions can be made about your medical care. We recommend that you contact your PCP's office regarding your desire to visit a specialist.

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

Obtaining Care after Normal Physician Office Hours

Most Physicians offer an after-hours answering service. For nonemergency situations, you should phone your Primary Care Physician. You can find your PCP's phone number in the Provider Directory.

If Emergency Health Care Services are needed, you should call 911 or seek treatment at an emergency room. If in need of Urgent Care, you may seek treatment at an Urgent Care Center that is available and open for business. Please note that some Urgent Care Centers are not open after 8 p.m. In such circumstances, it may be necessary to use an emergency room for care that is needed on an urgent basis. Please refer to the **Benefits Section, Accidental Injury (Trauma) / Urgent Care / Emergency**



Health Services / Observation Benefits Section of this Agreement for a detailed description of Coverage for Urgent and Emergency Health Care Services.

In-Network Practitioners/Providers

In-network Practitioners/Providers, including Primary Care Physicians, specialists, facilities and ancillary Healthcare Professionals, must be utilized, except in cases of an emergency. Members are responsible for paying the appropriate Cost Sharing (Deductible, Coinsurance and/or Copayments) directly to the In-network Practitioner/Provider at the time services are rendered when such amounts are clearly specified by the Practitioner/Provider. Hospital Inpatient Admission and some other Health Care Services require our review and **Prior Authorization** before the services are provided. If you seek care from an In-network Practitioner/Provider, your In-network Practitioner/Provider will notify us and handle all aspects of your care. If that Practitioner/Provider fails to obtain a required **Prior Authorization** and the claim is denied, you will not be held accountable for those charges. Please refer to the **Prior Authorization** Section for complete details on **Prior Authorization**.

Generally, you will not have claims to file or papers to fill out in order for a claim to be paid. The Practitioner/Provider will bill us directly for the cost of services. Most services require Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time of service. The amount of Cost Sharing for each service can be found in your *Summary of Benefits and Coverage*. In-network Practitioners and Providers cannot bill you for any additional costs over and above your Cost-Sharing amounts.

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

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

We do not require our In-network Practitioners/Providers to comply with any specified numbers, targeted averages, or maximum duration of patient visits. Presbyterian does not discriminate against any healthcare provider who is acting within the scope of their license or certification under applicable state law.

Out-of-network Practitioners/Providers

Out-of-network Practitioners/Providers are healthcare Practitioners/Providers, including non-medical facilities, who have not entered into an agreement with us to provide Health Care Services to PHP Members.

Covered Health Care Services obtained from an Out-of-network Practitioner/Provider or outside the Service Area will not be Covered unless such services are not reasonably available from an In-network Practitioner/Provider or in cases of an emergency. You will not pay higher or additional Cost-Sharing amounts under such circumstances. These provisions also apply to telehealth services.

If you pay a non-participating provider more than the In-network Cost-Sharing amount for services provided under circumstances giving rise to a surprise bill, the non-participating provider must refund to you within **45 calendar days** of receipt of payment from Presbyterian any amount paid in excess of the In-network Cost-Sharing amount. In accordance with the hearing procedures established pursuant to the Patient Protection Act [Chapter 59, Article 57 NMSA 1978], you may appeal Presbyterian's determination made regarding a surprise bill.

Services provided by an Out-of-network Practitioner/Provider, except Emergency services, require that your Primary Care Physician request and obtain written approval (Authorization) from our Medical Director before services are rendered. Otherwise, you may be responsible for payment. Please refer to the **Prior Authorization** Section for more information on **Prior Authorization** requirements.

If the services of an Out-of-network Practitioner/Provider are required, your In-network Practitioner/Provider must request and obtain **Prior Authorization** from our Medical Director before services are performed, otherwise, we may not Cover the services and you may be responsible for payment. Cost-Sharing and benefit limitations for a medically necessary, non-emergent healthcare service where no participating Provider is available to render the service will be the same as if the service was rendered by a participating provider.

Before the Medical Director may deny a request for specialist services that are unavailable from an In-Network Practitioner/Provider, the request must be reviewed by a specialist similar to the type of specialist to whom the **Prior Authorization** is requested.

In determining whether a **Prior Authorization** to an Out-of-network Practitioner/Provider is reasonable, we will consider the following circumstances:

- Availability – The In-network Practitioner/Provider is not reasonably available to see you in a timely fashion as dictated by the clinical situation.
- Competency – The In-network Practitioner/Provider does not have the necessary training or expertise required to render the service or treatment.

- Geography – The In-network Practitioner/Provider is not located within a reasonable distance from your residence.
- Continuity – If the requested Out-of-network Practitioner/Provider has a well-established professional relationship with you and is providing ongoing treatment of a specific medical problem, you will be allowed to continue seeing that specialist for a minimum of **30 days** as needed to ensure continuity of care.
- Any **Prior Authorization** requested simply for your convenience will not be considered to be reasonable.

Out-of-Network Care and Bills

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

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

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

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

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

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

- Call us first at **(505) 923-7258** or **1-855-923-7528** we will try to the resolve the issue with the Provider on your behalf.
- Contact the New Mexico Office of Superintendent of Insurance if the problem has not been resolved by us **www.osi.state.nm.us** or **1-855-4ASK-OSI (1-855-427-5674).**

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

- Notify you if your Provider leaves our network and allow you transitional care with that Provider at the In-network benefit level for up to **90 days** depending on your condition and course of treatment.
- Verify the accuracy of our Provider directory information at least every **90 days**.
- Confirm whether a Provider is In-network if you contact us at **1-855-923-7528**. If our representative provides inaccurate information that you rely on in choosing a Provider, you will only be responsible for paying your In-network Cost-Sharing amount for care received from that Provider.

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

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

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

- The Provider will owe you a refund within **45 days** of receipt of payment by us.
- If you do not receive a refund within that **45-day** period, the Provider will owe you the refund plus interest.
- You may contact the New Mexico Office of Superintendent of Insurance at **www.osi.state.nm.us** or **1-855-427-5674** for assistance or to appeal the Provider's failure to provide a refund. You need to file the appeal within **180 days** of the **45-day** refund period expiration.

Services of an Out-of-network Practitioner/Provider will not be Covered unless this **Prior Authorization** is obtained prior to receiving the services unless in urgent or emergent situations as defined by your plan. **You may be liable for the charges** resulting from failure to obtain **Prior Authorization** for services provided by the Out-of-network Practitioner/Provider.

Out-of-network Practitioners/Providers may require you to pay them in full at the time of service. You may have to pay them and then file your claim for reimbursement with us. We will only pay this claim if the service provided was Authorized by us or was due to an Urgent or Emergency Healthcare situation.

Restrictions on Services Received Outside of the PHP Service Area

Emergency Health Care Services and/or Urgent Care services outside of the state of New Mexico will be Covered. For Emergency Health Care Services and/or Urgent Care services received outside of New Mexico, you may seek services from the nearest appropriate facility where Emergency Health Care Services / Urgent Care services may be rendered. Cost Sharing and

benefits for an emergent or urgent healthcare service rendered by a non-participating provider shall be the same as if rendered by a participating provider.

Cost Sharing – Your Out-of-pocket Costs

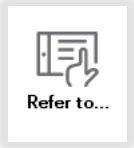
Many Health Care Services you receive from In-network and Out-of-network Practitioners and Providers require some payment from you. We refer to these payments as Cost Sharing. These are your Out-of-pocket costs and may be Deductibles, Coinsurance and/or Copayment amounts. Cost Sharing and benefits for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

Services for Limited Plans for American Indians and Alaska Natives

- For individual plans with zero Cost Sharing, American Indians/Alaska Natives do not have Cost Sharing when they receive covered services from In-network providers.
- For individual plans with limited Cost Sharing, American Indians/Alaska Natives do not have Cost Sharing when they receive covered services from an Indian healthcare provider, or from another provider if they have a referral from an Indian healthcare provider.

Annual Contract Year Deductible

Certain services are subject to an Annual Contract Year Deductible. The Annual Contract Year Deductible is the amount you and your Covered Dependents must pay for Covered Health Care Services each Contract Year before we begin to pay Covered Benefits for that Member. The Annual Contract Year Deductible may not apply to all Health Care Services. Refer to **What is the Out-of-pocket limit for this plan?** In your *Summary of Benefits and Coverage* for the amount of your Annual Contract Year Deductible.



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

For double or family coverage, the annual Contract Year deductible can be satisfied by any combination of the family members. No one member can contribute more than the stated

member amount. Once a member meets their individual amount their annual Contract Year deductible is considered met. The annual Contract Year Family and Individual Deductible amounts are listed in the *Summary of Benefits and Coverage*.

Changes to Deductible

Changes to the Deductible may only be made at renewal.

Coinsurance

Certain services are subject to a Coinsurance amount. Coinsurance is the percentage of Covered charges that you and your Covered Dependents must pay directly to the In-network Practitioner/Provider for Covered Services after the Annual Contract Year Deductible has been met. After you pay your Coinsurance amount, we will pay our percentage of the charges. Coinsurance is included in your Annual Out-of-pocket Maximum. The amount of your Coinsurance for each service can be found in your *Summary of Benefits and Coverage*.

Annual Out-of-pocket Maximum

This Plan includes an Annual Out-of-pocket Maximum amount to help protect you and your Covered Dependents from high-cost catastrophic healthcare expenses. The Annual Out-of-pocket Maximum is the most you will pay in Cost Sharing in a Contract Year for certain Covered Services. After you have met your Annual Out-of-pocket Maximum in a Contract Year, we pay **100%** of the cost for Covered Services, for the remainder of that Contract Year, up to the maximum benefit amount, if any. Refer to **What is the Out-of-pocket limit for this plan?** In your *Summary of Benefits and Coverage* for the Plan Annual Out-of-pocket Maximum.

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

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

The Annual Out-of-pocket Maximum includes Deductible, Coinsurance and Copayments. **It does not include** non-covered charges including charges incurred after the benefit maximum has been reached. PHP pays **100%** of Covered charges after the Out-of-pocket Maximum is met.

To inquire about the status of your specific Annual Out-of-pocket Maximum, you may call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**.

Office Visit Copayment

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

Utilization Management and Quality

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

Members may seek a second opinion when questions arise as to the medical appropriateness of a diagnosis or the appropriateness of medical and/or surgical services. Members may seek the second opinion from any In-network provider. If you'd like to request a second opinion from an Out-of-network provider. Presbyterian will assist you making the arrangements. Typical Cost Sharing will apply. If you'd like to request a second opinion from an Out-of-network provider, please call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**. Tell them you'd like to request a second opinion from an Out-of-network provider. Our Presbyterian Customer Service Center staff will submit the request to Utilization Management on your behalf.

Technology Assessment Committee

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

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

Transition of Care

If we terminate or suspend any contract with an In-network Practitioner/Provider from which you are currently receiving care, we will notify you, in writing, within **30 days**. We will assist you in locating and transferring to another similarly qualified In-network Practitioner/Provider, if available, for continued In-network benefits. You may elect to continue to receive care from this Out-of-network Practitioner/Provider; however, we will only reimburse for such services in accordance with applicable Out-of-network benefit level, if any, and then subject to Medicare Allowable Charges except when you wish to continue an ongoing course of treatment with the provider for a transitional period. This period shall continue for a time that is sufficient to permit coordinated transition planning consistent with your condition and needs relating to the continuity of the case and will not be less than **30 days**. If you are in your third trimester of pregnancy at the time of the provider's disaffiliation, your transitional period will last through the delivery and will allow for postpartum care. These transitional periods with your provider will not be allowed if the provider's disaffiliation was for reasons related to medical competence or professional behavior. For transitional periods exceeding **30 days**, continued care will be provided only if the provider agrees to accept reimbursement from Presbyterian at the rates applicable prior to the start of the transitional period as payment in full. Additionally, the provider must also agree to adhere to Presbyterian's quality assurance requirements, to provide necessary medical information related to such care, and to follow Presbyterian's policies and procedures, including but not limited to procedures regarding referrals, pre-authorization and treatment planning approved by Presbyterian.

Advance Directives

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

your wishes clear. You can create an Advance Directive at our website: **https://www.phs.org/tools-resources/patient/advance-directive**.

Prior Authorization

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

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

What is Prior Authorization?

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

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

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

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

Prior Authorization Is Required

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

If a required **Prior Authorization** is not obtained for services by Out-of-network Practitioners/Providers, except for Emergency Care, the Member may be responsible for the

resulting charges. Services provided beyond the scope of the **Prior Authorization** may not be Covered.

Prior Authorization when In-network

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

Prior Authorization when Out-of-network

Covered services obtained from an Out-of-network Practitioner/Provider or outside New Mexico will not be Covered unless such services are not reasonably available from an In-network Practitioner/Provider or in cases of an emergency.

If required medical services are not available from In-network Practitioners/Providers, the **Primary Care Physician must request Prior Authorization and obtain written Authorization** from our Medical Director before you may receive Out-of-network services. **Services of an Out-of-network Practitioner/Provider may not be Covered** unless in urgent or emergent situations as defined by your plan or this Authorization is obtained prior to receiving the services. You may be responsible for charges resulting from failure to obtain **Prior Authorization** for services provided by the Out-of-network Practitioner/Provider.

In determining whether a referral to an Out-of-network Practitioner/Provider is necessary, we, in consultation with your referring In-network Physician and/or PCP will consider the following circumstances:

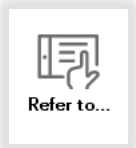
- Availability – The In-network Practitioner/Provider is not reasonably available to see you in a timely fashion as dictated by the clinical situation.
- Competency – The In-network Practitioner/Provider does not have the necessary training or expertise required to render the service or treatment.
- Geography – The In-network Practitioner/Provider is not located within a reasonable distance from the patient's residence.
- Continuity – If the requested Out-of-network Practitioner/Provider has a well-established professional relationship with you and is providing ongoing treatment of a specific medical problem, you will be allowed to continue seeing that specialist for a minimum of **30 days** as needed to ensure continuity of care.
- Any **Prior Authorization** requested simply for your convenience will not be considered to be reasonable.

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

Prior Authorization is required for Inpatient admissions, and all services related to the Inpatient admission before you receive these services In-network or Out-of-network from any Practitioner/Provider, Healthcare Facility or other Healthcare Professional unless in urgent or emergent situations as defined by your plan.

Our network of Practitioners/Providers will obtain **Prior Authorization** for you when you receive care In-network. You are responsible for obtaining **Prior Authorization** before you receive care Out-of-network, except for Emergency Care. Presbyterian will provide material that contains in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility and **Prior Authorization** requirements, within a reasonable time after enrollment and at subsequent periodic times as appropriate.

If you want to know more about **Prior Authorization** please call our Presbyterian Customer Service Center, as soon as possible before services are provided, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**.



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

After inception of coverage, Presbyterian Health Plan (PHP) will not expand the list of benefits for which **Prior Authorization** is required except when a new covered benefit is added to the plan, when safety or other concerns have arisen with respect to the benefit, when authorized by a state or federal regulatory agency, or as indicated by changes in nationally recognized clinical guidance. After inception of coverage, PHP will notify its network providers before adding a **Prior Authorization** requirement. PHP may remove a **Prior Authorization** requirement at any time. When PHP removes a **Prior Authorization** requirement during a plan year, PHP will notify its network providers of the change as soon as practicable, and no more than **60 days** after the requirement is removed.

For a guide of services that require **Prior Authorization**, visit **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000030435**.

- Acute Medical Detoxification
- All Hospital admissions, Inpatient non-emergent
- Applied Behavior Analysis
- Bariatric Services and Surgery for the treatment of obesity
- Clinical Trials (Investigational/Experimental)
- Certified Hospice Care

- Computed Axial Tomography (CAT) scans in an Outpatient setting
- Durable Medical Equipment
- Electroconvulsive Therapy (ECT)
- Epidural Injections for Back Pain
- Foot Orthotics
- Genetic/Genomic Testing
- Home Health Care Services/Home Health Intravenous Drugs
- Hyperbaric Oxygen
- Injectable Drugs, (includes Specialty Medications and Medical Drugs)
- Magnetic Resonance Imaging (MRI) in an Outpatient setting
- Major endoscopic procedures
- Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring Systems
- Nonemergency care when traveling outside the U.S.
- Nutritional Supplements
- Observation Services greater than **24 hours**
- Organ transplants/Transplant Services
- Custom Orthotics
- Operative and cutting procedures
- Positron Emission Tomography (PET) scans in an Outpatient setting
- Prescription Drugs/Medications
- Preoperative and postoperative care
- Prosthetic Devices
- Proton Beam Irradiation
- Reconstructive and potentially cosmetic procedures
- Selected Surgical/Diagnostic procedures:
    - Blepharoplasty/Brow Ptosis Surgery
    - Breast Reconstruction following Mastectomy
    - Breast reduction for gynecomastia
    - Endoscopy Nasal/Sinus balloon dilation
    - Hysterectomy
    - Lumbar/Cervical Spine Surgery
    - Meniscus Implant and Allograft/Meniscus Transplant
    - Panniculectomy
    - Rhinoplasty
    - Tonsillectomy
    - Total Ankle Replacement
    - Total Hip Replacement
    - Total Knee Replacement
    - Varicose Vein Procedures
- Skilled Nursing Facility care
- Special Inpatient services, for example, private room and board and/or special duty nursing

- Special Medical Foods
- Substance Use Disorder services, Inpatient
- Transcranial Magnetic Stimulation
- Virtual Colonoscopy
- Wireless Capsule Endoscopy

Prescription drug Prior Authorization protocols

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

No later than **24 months** after the adoption of national standards for electronic **Prior Authorization**, a health insurer shall exchange **Prior Authorization** requests with providers who have e-prescribing capability.

If a healthcare plan fails to use or accept the uniform **Prior Authorization** form or fails to respond within **three business days** upon receipt of a uniform **Prior Authorization** form, the **Prior Authorization** request shall be deemed to have been granted.

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

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

Authorizing Inpatient Hospital Admission following an Emergency

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

Prior Authorization and Your Coverage

- Eligibility and benefits are based on the date you received the services, not the date you received **Prior Authorization**.

- If you lose Coverage under this plan, services received after Coverage ends will not be Covered, even if we provided **Prior Authorization**.

Prior Authorization Decisions – Nonemergency

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

Prior Authorization Decision – Expedited (Accelerated)

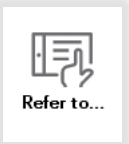
If your medical condition requires that we make a **Prior Authorization** decision quickly, we will notify you and your Practitioner/Provider of an expedited decision, within **24 hours** of our receipt of the written or verbal request for an expedited decision.

Prior Authorization Review – Initial Adverse Determination

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

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

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



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

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

Prior Authorization

Prior Authorization Requirement

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

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

A complete and current list of the services subject to **Prior Authorization** can be found here: **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000030435**. The prescription drugs that are subject to a **Prior Authorization** requirement can be found at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739**.

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

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

- Emergency services;
- Contraception services that are not subject to any Cost Sharing;
- An obstetrical or gynecological ultrasound, or;
- The following mental health and Substance Use Disorder services:
    - Acute or immediately necessary care;
    - Acute episodes of chronic mental health or Substance Use Disorder conditions; or
    - Initial In-network Inpatient or Outpatient substance use treatment services.
    - Please see the "Mental Health and Substance Use Disorder Service Coverage" section for additional information.

Additionally, coverage for medication approved by the Federal Food and Drug Administration that is prescribed for the treatment of autoimmune disorder, cancer, rare disease or condition or Substance Use Disorder is also not subject to **Prior Authorization**, pursuant to a medical necessity determination made by a healthcare professional from the same or similar practice specialty that typically manages the medical condition, procedure or treatment under review.

- The healthcare provider who is managing the patient's rare disease or condition must have a baseline understanding of the nature of the patient's rare disease or condition or seek the help of someone in the same or similar specialty and act under their direction even if that specialist is not available within the state.
- To ensure medically necessary determinations are completed in a timely manner, time frames for medically necessary determinations are as follows:
    - **Seven** business days standard determinations; and

- **24 hours** for emergency determinations when a delay in treatment could be harmful to you.

It is important to note that **Prior Authorizations** for the treatment of an autoimmune disorder, cancer, rare disease or condition or a Substance Use Disorder, are allowed in cases in which a biosimilar, interchangeable biologic, or generic version is available. We require authorization for continued Inpatient care if you are admitted to a hospital for emergency treatment, but your condition is stabilized. You or your provider must notify us as soon as possible from when you begin receiving emergency Inpatient treatment, and within **24 hours** after the emergency ends and your condition stabilizes.

Prior Authorization protocols

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

No later than **24 months** after the adoption of national standards for electronic **Prior Authorization**, a health insurer shall exchange **Prior Authorization** requests with providers who have e-prescribing capability.

If a healthcare plan fails to use or accept the uniform **Prior Authorization** form or fails to respond within **three business days** upon receipt of a uniform **Prior Authorization** form, the **Prior Authorization** request shall be deemed to have been granted.

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

- A person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income.

Prior Authorization Process

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

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

and submit it sooner, we encourage you to have your Provider request **Prior Authorization** whenever possible.

Prior Authorization Review Timelines

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

- Urgent Care or Prescription Drugs
    - If you require urgent medical care, behavioral healthcare or a prescription drug, we will resolve the request within **24 hours**.
- Non-Urgent Medicine
    - If you do not have an urgent need for a prescription drug, we will resolve the request within three business days if your provider:
    - Uses the **Prior Authorization** request form approved by the New Mexico Office of Superintendent of Insurance;
    - Requests an exception from an established step-therapy process; or
    - Requests to prescribe a drug that we do not usually cover.
- Standard (Non-Urgent) Medical Care Requests
    - For all other requests related to medical services (not prescription drugs), we will make a determination within seven business days, unless a shorter timeframe is required by law.

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

Why We Review

Our review of a **Prior Authorization** request will determine if the proposed care involves a covered service, is medically necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning medical necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional.

Prior Authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review

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

Behavioral Health Care

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

Authorization Denial

We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree.

You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

Record of Prior Authorization

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

Prescription drug Prior Authorization protocols

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

No later than **24 months** after the adoption of national standards for electronic **Prior Authorization**, a health insurer shall exchange **Prior Authorization** requests with providers who have e-prescribing capability.

If a healthcare plan fails to use or accept the uniform **Prior Authorization** form or fails to respond within **three business days** upon receipt of a uniform **Prior Authorization** form, the **Prior Authorization** request shall be deemed to have been granted.

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

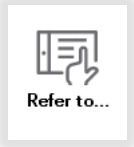
- A person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income.
- A physician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

Benefits

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

Specifically Covered

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



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

We determine whether a Health Care Service or supply is a specifically Covered Benefit.

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

Medical Necessity

This Health Care Benefit Plan helps pay for healthcare expenses that are Medically Necessary and specifically Covered in this Agreement. Clinical Preventive Health Services do not have to be "Medically Necessary."

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

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

Care Coordination and Case Management

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

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

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

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

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

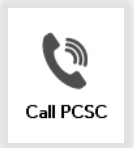
PresRN

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

Health Management Programs

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

well as with disease management for conditions such as asthma, coronary artery disease, diabetes, and/or hypertension.



If you would like more information about these services, visit **https://www.phs.org/tools-resources/member**. Members can also call our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Other Programs and Services

Employee Assistance Program

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

MyChart

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

Wellness at Work

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

Covered Benefits

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

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

Urgent Care

This Agreement covers acute Urgent Care triage **24 hours** a day, **seven days** a week, when those services are needed immediately to prevent jeopardy to your health. Urgent Care is Medically Necessary medical or surgical procedures, treatments, or Healthcare Services you receive in an Urgent Care Center or in a Practitioner's/Provider's office for an unforeseen condition due to illness or injury. Urgent conditions are not life-threatening but require prompt medical attention to prevent a serious deterioration in your health. If you believe the condition to be treated is life-threatening, you should seek Emergency Healthcare Services as outlined below.

- Members are encouraged to contact their PCPs for an appointment, if available, before seeking care from another Practitioner/Provider.
- We must Prior Authorize follow-up care by an Out-of-network Practitioner/Provider. **The Member will be responsible for charges that we do not Cover.**
- Urgent care shall be available within **48 hours** of notification to the PCP or Plan, or sooner as required by the medical exigencies of the case.

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

Emergency Health Care Services

This Agreement covers acute Emergency Health Care Services **24 hours** a day, **seven days** a week, when those services are needed immediately to prevent jeopardy to your health. You should seek medical treatment from an In-network Practitioner/Provider or facility whenever possible.

If you cannot reasonably access an In-network Facility, we will arrange to Cover the care at an Out-of-network facility at the In-network benefit level. Whether Out-of-network Emergency Health Care Service is appropriate will be determined by the Reasonable/Prudent Layperson standard discussed below.

- We will provide reimbursement excluding ambulance transportation service, which procedure, treatment or service is delivered to a covered person after the sudden onset of

what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person; or

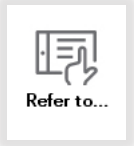
- For trauma services and all other emergency services until the member is medically stable, does not require critical care, and can be safely transferred to an In-network facility, if required, based on the judgment of the attending physician.

If the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Disfigurement to the person
- Any circumstance that prevented you from using our established procedures for obtaining Emergency Healthcare Services

Prior Authorization is not required for Emergency Health Care Services. If you are admitted as an Inpatient to the Hospital, you or your Practitioner needs to notify us as soon as possible so we can review your Hospital stay.

We will not deny a claim for Emergency Health services when the Member was referred to the emergency room by their PCP or by our representative.



If your Emergency Health services results in a hospitalization directly from the emergency room, you are responsible for paying the Inpatient Hospital Cost-Sharing amounts (Deductible, Coinsurance and/or Copayment) rather than the emergency room visit Copayment. Refer to Ambulance Services in your *Summary of Benefits and Coverage* for the required Cost Sharing for inter-facility transportation costs.

For Emergency Health Care Services received Out-of-network and/or (our Service Area), you may seek Emergency Health Care Services from the nearest appropriate facility where Emergency Health Care Services can be rendered. **Non-emergent follow-up care received outside of New Mexico is not Covered** unless transfer to an In-network Practitioner/Provider would be medically inappropriate and a risk to your health. In such circumstances, we must Authorize the Health Care Services. **Non-emergent follow-up care outside of New Mexico is not Covered** for your convenience or preference. **You are responsible for any such charges that we do not Authorize.**

Follow-up care from an Out-of-network Practitioner/Provider requires our **Prior Authorization**.

Observation Services

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

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

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

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

Ambulance Services

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

The following types of Ambulance Services are Covered:

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

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

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

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

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

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

Coverage for High-Risk Ambulance Services is limited to:

- Air ambulance service when medically necessary. However, a plan may not pay more for air ambulance service than it would have paid for transportation over the same distance by ground ambulance services, unless your condition renders the utilization of such ground ambulance services medically inappropriate.
- Neonatal Ambulance Services, including ground or air Ambulance Service to the nearest Tertiary Care Facility when necessary to protect the life of a newborn.
- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

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

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

Allergy Testing and Treatment

This plan provides coverage for allergy testing and treatment.

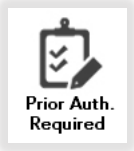
Anesthesia

These benefits include coverage for anesthesia and the administration of anesthesia. Anesthesia may be billed separately from other medical services or procedures, and you may incur separate Cost Sharing. Anesthesia may include coverage of hypnotherapy. General anesthesia may be provided where local anesthesia is ineffective because of acute infection, anatomic variation or allergy.

Bariatric Surgery

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

Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m^2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions; and **Prior Authorization** is required and services must be performed at an In-network facility that is designated by Presbyterian Health Plan, and designated as an accredited bariatric surgery Center by the American Society of Metabolic and Bariatric Surgery/American College of Surgeons.



Biofeedback

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

Biomarker Testing

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

Cancer or Other Life-threatening Medical Condition Clinical Trials

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

These benefits include coverage for cancer or other life-threatening medical condition clinical trials.

Coverage for routine patient care costs means a:

- Medical service or treatment that is a benefit under this plan that would be covered if the patient were receiving standard cancer treatment or other treatment for a life-threatening medical condition, or
- Drug provided to a patient during a clinical trial if the drug has been approved by FDA, whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for the manufacturer, distributor or provider of the drug.

Routine patient care costs are covered for members in a clinical trial if:

- The patient encounters other life-threatening diseases or conditions during the course of treatment;
- The clinical trial is undertaken for the purposes of the prevention of or the prevention of reoccurrence, early detection, or treatment of cancer or other life-threatening medical treatment for which no equally or more effective standard treatment exists;
- The clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent;
- The clinical trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention;
- There is no non-investigational treatment equivalent to the clinical trial;
- There is a reasonable expectation shown in clinical or preclinical data that the clinical trial will be at least efficacious as any non-investigational alternative; or
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

The clinical trial is being conducted with the approval of at least one of the following:

- One of the federal National Institutes of Health
- A federal National Institute of Health cooperative group or center
- The federal Department of Defense
- The FDA in the form of an investigational new drug application
- The federal Department of Veterans Affairs

- A qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility
- A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility
- The Agency for Health Research and Quality (AHRQ)
- The Centers for Medicare and Medicaid Services (CMS)
- The Department of Energy (DOE)

The personnel providing the clinical trial or conducting the study:

- Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise;
- Agree to accept reimbursement as payment in full from the health plan at the rates that are established by that plan and are not more than the level of reimbursement applicable to other similar services provided by healthcare providers within the plan's provider network;
- Agree to provide written notification to the health plan when a patient enters or leaves a clinical trial;
- There is no non-investigational treatment equivalent to the clinical trial;
- The available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative;
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment; and
- Routine patient costs outside of the state in which the individual resides.

Limitations: The following limitations apply.

- Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial.
- A health plan shall not provide benefits that supplant a portion of a clinical trial that is customarily paid for by government, biotechnical, pharmaceutical, or medical device industry sources.
- In no event shall the health plan be responsible for out-of-state or Out-of-network costs unless the health plan pays for standard treatment out-of-state or Out-of-network. In no event shall the health plan be responsible for out-of-state costs for any trials undertaken for the purposes of the prevention of or the prevention of recurrence of cancer or other life-threatening illness.

Certified Hospice Care

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

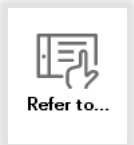
Benefits for Inpatient and in-home Hospice services are Covered if you are terminally ill. Services must be provided by an approved Hospice program during a Hospice benefit period and will not be Covered to the extent that they duplicate other Covered Services available to you. Benefits that are provided for by a Hospice or other facility require approval by your Practitioner/Provider and our **Prior Authorization when In-network** section.

The Hospice benefit period is defined as follows:

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

The following services are Covered:

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



Where there is not a certified Hospice program available, regular Home Health Care Services benefits will apply. Refer to the **Home Health Care Services/Home Intravenous Services and Supplies** Section of this Agreement.

Chemotherapy and Radiation Therapy

Your benefits include coverage for the use of chemical agents or radiation to treat or control a serious illness.

Clinical Preventive Health Services

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

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

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

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

- Screening and Counseling Services
- Routine Immunizations
- Adult Preventive Services
- Childhood Preventive Services
- Preventive Services for Women
- Other Services

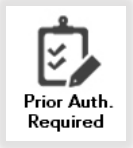
You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/patient/preventive-care-guidelines**.

Screening and Counseling Services

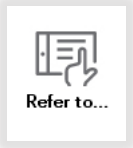
Screenings and counseling services will provide coverage for evidence-based services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) for individuals in certain age groups or based on risk factors. Key screenings include but are not limited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

- Abdominal aortic aneurism screening for men ages **65 to 75 years** old who have ever smoked.
- Anxiety in Children and Adolescents: Screening ages **8 to 18 years** old.
- Prediabetes and Type 2 diabetes mellitus screening for adults ages **35 to 70 years** old who are overweight or obese.

- Screening for human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and domestic violence and abuse.
- Heart Artery Calcification scans are a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function. These scans are Covered for individuals between the ages of **45-65 years**. Refer to the Heart Artery Calcification section for more details. Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- Falls prevention screening for adults **age 65** or older.
- Hepatitis B screenings for persons at high risk of infection.
- Hepatitis C screenings for adults ages **18 to 79 years** old.
- Latent tuberculosis screening for high-risk populations.
- Lung cancer screenings for ages **50 to 80 years** with a history of Tobacco.
- Preventive Physical Examinations.
- Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication adults aged **40 to 75 years** who have one or more cardiovascular risk factors.
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam.
- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level.
- Periodic stool examination for the presence of blood for all persons **45-75 years** of age.
- Colorectal cancer screening in accordance with the evidence-based recommendations established by the USPSTF for determining the presence of precancerous or cancerous conditions and other health problems including:
    - Fecal occult blood testing (FOBT).
    - Flexible sigmoidoscopy.
    - Colonoscopy, and polyp removal when performed as a screening.
        - Anesthesia services are also at no Cost Share to Covered members when performed as part of Colonoscopy screening.
    - Virtual colonoscopy – requires **Prior Authorization**.
    - Double contrast barium enema.



- After a colonoscopy, any pathology exam that's required for a biopsy anesthesia a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test.
- Tobacco Cessation Program – refer to Tobacco Cessation Counseling/Program in this Section.
- Screening to determine the need for vision and hearing correction in children. Periodic glaucoma eye test.



- Healthy Weight and Weight Gain in Pregnancy: Behavioral Counseling Interventions
- Hypertension in Adults: Screening adults **18 years or older** without known hypertension.

- Syphilis infection screening in persons who are at an increased risk for infection and pregnant women.
- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV, STIs, and counseling, as well as counseling for drug and Tobacco use, healthy eating and other common health concerns.
- Health education and consultation from In-network Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or Tobacco control, nutrition, and diet recommendations, and exercise plans. For Members **19 years** or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.
- Certain prescription drugs for preventive care, the treatment of illness, behavioral health, or Substance Use Disorders will be Covered at No Charge to you, when obtained from a participating pharmacy. See your Plan's Covered drug list for details.

Mammography Services

The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than **age 40** years and no later than **age 50**. Screening mammography should occur at least biennially and as frequently as annually. Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography. If additional imaging (e.g., magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies. Screening should continue through at least **age 74**, and age alone should not be the basis for discontinuing screening. Women at increased risk also should undergo periodic mammography screening, however, recommendations for additional services are beyond the scope of this recommendation. After July 1, 1992, coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American College of Radiology accreditation standards for mammography. These scans are covered.

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

Pre-Exposure Prophylaxis Coverage Summary
Pre-Exposure Prophylaxis (PrEP)

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

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

What is Covered?

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

Grievance and Appeals Process

If you were charged Cost Sharing for coverage of PrEP medication or PrEP-related services on or after January 1, 2021, please call our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. If you would like to submit a grievance, the customer service representative can submit the request for you.

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

Address: Presbyterian Health Plan
Attn.: Appeals and Grievance Department

P.O. Box 27489
Albuquerque, NM 87125-7489
Phone: **(505) 923-7528** or **1-855-923-7528**
Fax: **(505) 923-6111**
Email: **gappeals@phs.org**

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:

Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689
Santa Fe, NM 87504-1689
Phone: **(505) 827-4601** or **1-855-427-5674**
Fax: **(505) 827-4253**, Attn.: MHCB
Email: **mhcb.grievance@osi.nm.gov**
File complaint: **http://www.osi.state.nm.us/pages/misc/mhcb-complaint**

Exception Process

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

Standard Review

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

Expedited Review

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

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

For more information or assistance with your complaint, grievance or an exception request, you may contact the Managed Health Care Bureau (MHCB) of the Office of Superintendent of Insurance at:

Address:	Office of Superintendent of Insurance - MHCB P.O. Box 1689 Santa Fe, NM 87504-1689
Phone:	**(505) 827-4601** or **1-855-427-5674**
Fax:	**(505) 827-4253**, Attn.: MHCB
Email:	**mhcb.grievance@osi.nm.gov**
File complaint:	**http://www.osi.state.nm.us/pages/misc/mhcb-complaint**

Routine Immunizations

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

- The American Academy of Pediatrics.
- The Advisory Committee on Immunization Practices Centers for Disease Control and Prevention.
- The USPSTF.
    - Immunizations for routine use in children, adolescents, and adults that have, in effect, a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved.
    - HPV Vaccine coverage for the Human Papillomavirus as approved by the FDA and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).

Childhood Preventive Health Services

Childhood Preventive Health Services includes Coverage for Well-child Care in accordance with the recommendations of the USPSTF.

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

You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/patient/preventive-care-guidelines**.

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

- Anxiety in Children and Adolescents: Screening ages **8 to 18 years** old.
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sports, school, or camp activities.
- Hearing and Vision screening for correction. This does not include routine eye exams or Eye Vision and Hearing screening to determine Refractions performed by eye care specialists. One Eye Refraction per Contract Year is Covered for children under **age 6** when Medically Necessary to aid in the diagnosis of certain eye diseases.
- Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions.
- Pediatric Vision – Please refer to the Rider at the end of this Agreement for benefit coverage and details.
- Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
- Behavioral Assessments.
- Screening for Alcohol and drug use, anemia, blood pressure, congenital hypothyroidism, depression, developmental development and surveillance, dyslipidemia, hematocrit/hemoglobin or sickle cell, lead, obesity, oral health, STIs, Phenylketonuria (PKU) and Tuberculin testing.
- Skin cancer prevention behavioral counseling.
- Counseling from Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or Tobacco control, nutrition and diet recommendations, and exercise plans. For Members under **19 years** of age, this includes (as deemed appropriate by the Member's Practitioner/Provider or as requested by the parents or legal guardian) education information on Alcohol and Substance Use Disorder, STIs, and contraception.
- Preventive benefits, as defined by the Affordable Care Act (ACA) for all recommended preventive services, including services related to pregnancy, preconception and prenatal care.

Preventive Health Services for Women

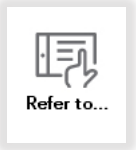
We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider. Women cannot be charged more than persons seen by a PCP for choosing a women's healthcare provider as her PCP.

You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/member/health-wellness-information**.

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

- Well-woman visits to include adult and female-specific screenings and preventive benefits.
- Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication.
- Breast Cancer: Medication Use to Reduce Risk.
- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for **one year** after delivery.
- Cervical cancer screening for women ages **21 to 65 years** old.
- Chlamydia and gonorrhea screenings for sexually active women age **25 years** or younger and for older women at increased risk for infection.
- Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Coverage for contraception is not subject to Cost Sharing, Utilization Review, **Prior Authorization**, step-therapy requirements, or any other restrictions or delays on coverage.
    - Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000007352**.
    - Coverage of a six-month supply of contraceptives at one time, provided that the contraceptives are prescribed and self-administered.
- Counseling and screening for HIV, STIs and domestic violence and abuse.
- Domestic and interpersonal violence screening and counseling for all women.
- Counseling interventions for pregnant and postpartum persons who are at an increased risk of perinatal depression.
- Gestational diabetes screening for women **24 to 28 weeks** pregnant and those at high risk of developing gestational diabetes.
- HIV screening and counseling for sexually active and pregnant women. For pregnant women, the screening will be covered at any point of the pregnancy, even those who present in labor with an unknown status.
- Cervical cancer screening every three years for women **21-65 years** of age who are at average risk.
- HPV DNA test: High-risk HPV DNA testing every **three years** for women with normal cytology results.
- HPV vaccine coverage for HPV as approved by the FDA and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).
- Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication for pregnant persons at high risk for preeclampsia.

- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling.
- Sexually Transmitted Infections (STI) counseling for sexually active women.
- Sterilization services for women only. Other services, performed during the procedure, are subject to deductible and coinsurance as outlined in your *Summary of Benefits and Coverage*.
- Urinary incontinence screening.



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

Clinical Trials

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

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

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

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

1. Conducted under an investigational new drug application reviewed by the FDA;
2. A drug trial that is exempt from having such an investigational new drug application; OR
3. Is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    a. The National Institutes of Health;
    b. The Centers for Disease Control and Prevention;
    c. The Agency for Health Care Research and Quality;
    d. The Centers for Medicare and Medicaid Services;
    e. A cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs;

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; OR
g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the Secretary of Health and Human Services determines that the study has been reviewed and approved through a system of peer review that (i) is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the 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 collections 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.

Complementary Therapies

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

Acupuncture

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

These benefits cover acupuncture and acupressure treatment. Services are limited to **20 visits** per Contract Year unless for rehabilitative or habilitative purposes. There are no limits on services for habilitative or rehabilitative services. The visit limits apply to services for non-habilitative or non-rehabilitative services.

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

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

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

Chiropractic Services

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

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

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

COVID-19

As a Presbyterian Health Plan Member, there will be no cost to you for anything related to COVID-19 testing, medical treatment, or vaccination, including boosters testing/screening for

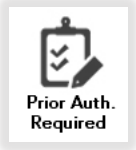
pneumonia or influenza, treatment for pneumonia when due to or as a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19, or any disease or condition which is the cause of public health emergency when declared by the state of New Mexico or federal government. You will not pay copays, deductibles or coinsurance for visits related to COVID-19, whether at a clinic, hospital or using remote care.

Dental Services (Limited)

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

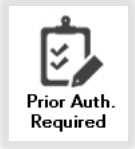
Dental benefits will be provided in connection with the following conditions when deemed Medically Necessary except in an emergency situation as described in the **Accidental Injury (trauma), Urgent Care, Emergency Health Care Services** and **Observation Services Section**. Covered Services are as follows:

- Accidental Injury to sound natural teeth, jawbones or surrounding tissue. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury and will not be Covered**.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Hospitalization, day surgery, Outpatient and/or anesthesia for non-Covered dental services, are Covered, if provided in a Hospital or ambulatory surgical center for dental surgery, with our approval of a **Prior Authorization** request. Plan benefits for these services include coverage:



    - For Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
    - For Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
    - For Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
    - For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

    - For other procedures for which Hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Pediatric dental services, including routine check-ups, major dental care, and orthodontia.
- Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- **Temporo/Craniomandibular Joint Disorders (TMJ/CMJ).**
    - The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Custom Orthotic Devices (TMJ splints) are subject to the same conditions, limitations, as they apply to treatment of any other joint in the body.



Diabetes Services

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

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

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

Coverage for Individuals with Diabetes

Your health benefits plan contract provides coverage for basic health services for individuals with Type 1 diabetes (insulin dependent diabetes), Type 2 diabetes (non-insulin dependent diabetes), and gestational diabetes (individuals with elevated blood glucose levels induced by pregnancy). These basic health services consist of:

- Preventive care
- Emergency care
- Inpatient and Outpatient hospital and physician care
- Diagnostic laboratory services

- Diagnostic and therapeutic radiological services
- Prescription medications
- Treatment and supplies

This coverage is a basic healthcare service that entitles you to the medically accepted standard of medical care for diabetes, when medically necessary, and will not be reduced or eliminated.

Generally, your provider will diagnose you with diabetes and prescribe medically necessary Durable Medical Equipment (DME), diabetic testing supplies, insulin, or other prescription medications used for the treatment of diabetes. Generally, once a provider diagnoses you with diabetes, any provider can then prescribe medically necessary DME, diabetic testing supplies, insulin, or other prescription medications.

This section explains covered benefits and services. Nothing in this section of your plan contract shall be construed to require payment for diabetes resources that are not covered benefits or services.

Basic Health Care Services

Your health benefits plan covers the following benefits for diabetes self-management training provided by a certified, registered or licensed healthcare professional with recent education in diabetes management:

- Medically necessary visits upon the diagnosis of diabetes;
- Visits following a diagnosis indicating a significant change in your symptoms or condition that warrants changes in your self-management;
- Visits when re-education or refresher training is prescribed by your provider with prescribing authority;
- Phone visits with a Certified Diabetes Educator (CDE). Approved diabetes educators may be required to be practitioners/providers who are registered, certified or licensed healthcare professional with recent education in diabetes management; and
- Medical nutrition therapy related to diabetes management.

Prescription Medications, DME, Insulin and Supplies

Your plan contract covers DME, diabetic testing supplies, insulin or other prescription medications needed to monitor and control your diabetes as follows:

- Insulin pumps when medically necessary, prescribed by a provider;
- Blood glucose monitors, including those for individuals with disabilities;
- Specialized monitors/meters for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading urine and ketone strips;
- Lancets and lancet devices;

- Insulin;
- Injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;
- Syringes;
- Oral diabetic prescription medications for controlling blood sugar levels;
- Glucagon emergency kits; and
- Medically necessary podiatric DME for prevention of feet complications associated with diabetes as follows:
    - Therapeutic molded or depth-inlay shoes;
    - Functional orthotics;
    - Custom molded inserts;
    - Replacement inserts;
    - Preventive devices; and
    - Shoe modifications for prevention and treatment.

Your health benefits plan requires the use of approved DME brands that are purchased at In-network pharmacy, preferred vendor or preferred durable medical equipment supplier.

This health benefits plan will also cover items not specifically listed as covered when new and improved DME and prescription medications for the treatment and management of diabetes are approved by the FDA. When such items are approved, we will update our *Formulary* and other information to provide adequate access to these resources. Coverage of newly approved prescription medications for the treatment and management may be subject to **Prior Authorization** and step-therapy requirements.

Prior Authorization

Medically necessary DME, diabetic testing supplies, insulin or other prescription medications used for the treatment of diabetes and covered under your health benefits plan can be subject to **Prior Authorization** and step-therapy requirements. We will not require your provider to submit more than one **Prior Authorization** request per policy year for any single medication or category of covered item, unless there is a change in your diagnosis, management or treatment of diabetes or its complications. The one **Prior Authorization** per year limitation applies to changes in the following:

- Prescribed dose of a medication;
- Quantities of supplies needed to administer a prescribed medication;
- Quantities of blood glucose self-testing equipment and supplies; or
- Quantities of supplies needed to use or operate devices for which an enrollee has received **Prior Authorization** during the policy year shall not be subject to additional **Prior Authorization** requirements in the same policy year if deemed medically necessary by the enrollee's health care practitioner.

Cost Sharing

The amount you will pay for a preferred *Formulary* prescription insulin, or a medically necessary alternative will not exceed a total of **$25** per **30-day** supply. Coverage of all other diabetes-related benefits, treatment and supplies may be subject to Cost Sharing (Deductible, Copay and Coinsurance) consistent with the Cost Sharing imposed to other benefits under the same contract. This Cost Sharing will not exceed the Cost Sharing established for similar benefits under your health benefits plan.

Network Access

We maintain an adequate network of providers, pharmacies, durable medical equipment suppliers and other suppliers to provide you with adequate and timely access to medically necessary diabetes resources. If a contract lapses or is terminated, we will ensure the availability and continuity of your care through another network provider or a single-case agreement with an Out-of-network provider.

Reimbursement

We guarantee coverage for the medically necessary DME, diabetic testing supplies, insulin or other prescription medications, in this section within the limits of your health benefits plan. We will reimburse you if the before mentioned benefits were not accessible in a timely manner and you incurred Out-of-pocket expenses.

If you are unable to access medically necessary DME, diabetic testing supplies, insulin or other prescription medications covered under this health benefits plan in a timely manner, and when needed, you can:

- Contact us at **(505) 923-7528** or **1-855-923-7528 (TTY 711)** and we will assist you with finding an In-network provider or refer you to an Out-of-network Provider that can deliver the benefit or service in a timely manner; or
- Pay Out-of-pocket and file a claim with us at **(505) 923-7528** or **1-855-923-7528 (TTY 711)**. We will reimburse you the amount of the covered benefit on the same basis as if the benefit was obtained In-network. Once we receive your written request and receipt for Out-of-pocket expenses, we will reimburse you within **30 days.** If we fail to reimburse you in a timely manner, we will pay an interest rate of **18%** per year on the amount due.

If you are not satisfied with our resolution you can file a complaint with the Office of the Superintendent of Insurance at **https://www.osi.state.nm.us/pages/misc/mhcb-complaint** or by calling **1-855-427-5674, Option 3**. The specific review criteria used by the OSI when conducting a compliance review required by House Bill 53 (HB 53) Delivery of Necessary Diabetic Resources will be provided on the OSI website at **https://www.osi.state.nm.us/**.

Diabetes Education and Self-Management training (Limited)

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

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

Limitations: Approved diabetes educators must be part of our In-Network Practitioners/Providers who are registered, certified or licensed Healthcare Professional with recent education in diabetes management.

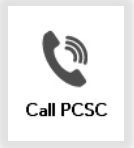
Diabetes supplies, equipment, appliances and services

The following equipment, supplies, appliances, and services are Covered when prescribed by your Practitioner/Provider and when obtained through the designated network Provider. These items require the use of approved brands and may be required to be purchased at In-network pharmacy, preferred vendor or preferred durable medical equipment supplier.

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

Some services may require **Prior Authorization**. Please contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. **TTY** users may call **711**. You may also visit **https://www.phs.org/doctors-services/supporting-services/pharmacy-services**.

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



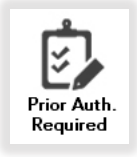
These items require the use of approved brands and must be purchased at an In-network Pharmacy, Preferred vendor or Preferred Durable Medical Equipment (DME) supplier. Please contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. **TTY** users may call **711**. You may also visit our website at **www.phs.org** for further information.

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

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

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

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



- Artery calcification testing (plan year 2022 and after)
- Biomarker testing
- Computerized Axial Tomography (CAT) scans – requires **Prior Authorization**
- Magnetic Resonance Angiogram (MRA) tests, Magnetic Resonance Imaging (MRI) tests – require **Prior Authorization**
- Sleep disorder studies in home or facility may require **Prior Authorization**
- Bone density studies
- Clinical laboratory tests – may require **Prior Authorization**

- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiology/X-ray services
- Diagnostic Breast Exams
- Supplemental Breast Exams

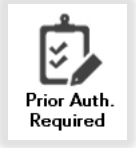
Diagnostic service includes services like mammography, PAP Smears and colonoscopies that are also considered Preventive and are provided to you at **$0** Cost Share. Some services like exploratory surgery, angiograms, **imaging**, or follow-up procedures to Preventive services can also be diagnostic,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

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

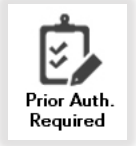
This benefit has one or more exclusions as specified in the **Exclusions Section**.

Durable Medical Equipment

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



Orthotic Appliances



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

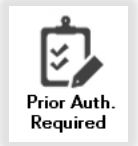
Orthotic Appliances are subject to the following **limitations**:

- Foot Orthotics or shoe appliances are not Covered, except for our Members with diabetic neuropathy or other significant neuropathy.

    - Durable medical equipment for the treatment of active diabetic foot ulcers, including topical oxygen therapy is covered.
- Custom fabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for our Members in accordance with nationally recognized guidelines.
- Covered Custom Orthotic Appliances including:
    - Podiatric appliances for prevention of feet complications associated with diabetes.
    - Repair and replacement of durable medical equipment, prosthetics and custom orthotic devices must comport with state law. Please see the Diabetes Section.

Prosthetic Devices

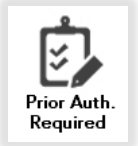
Standard Prosthetic Devices are artificial devices, which replace or augment a missing or impaired part of the body. The purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are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



Examples of Prosthetic Devices include but not limited to:

- Breast prostheses when required because of mastectomy and prophylactic mastectomy
- Artificial limbs
- Prosthetic eye
- Prosthodontic appliances
- Penile prosthesis
- Joint replacements
- Heart pacemakers
- Tracheostomy tubes and cochlear implants

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



Repair and replacement of Durable Medical Equipment, Prosthetics and Custom Orthotic Devices requires **Prior Authorization**. Repair and replacement are Covered when Medically Necessary due to change in your condition, wear or after the product's normal life expectancy has been reached.

Repair and replacement are Covered when Medically Necessary due to change in your physiological condition, irreparable change in the condition of the device, or repairs would be more than **60%** of the cost of a replacement, wear or after the product's normal life expectancy

has been reached. If the device is less than three years old and prescribed by a healthcare provider, **Prior Authorization** may be required.

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

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

Medical Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics

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

- Clinical care.
- All supplies, materials, and devices determined by the physician to be medically necessary and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such but not limited to running, biking, swimming, strength training.
- All services, including design, fabrication, and repair.
- Replacement, without regard to reasonable useful lifetime restrictions, including replacement necessary due to a change in the patient's condition or the condition of the device if replacement the device requires repairs costing more than **60%** of replacement cost.
- Access to prosthetic and custom orthotic devices from at least two distinct device providers in your network.

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

Surgical Dressing

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

Gradient compression stockings are Covered for:

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

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

Eyeglasses and Contact Lenses (Limited)

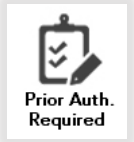
The following will only be Covered:

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

Hearing Aids

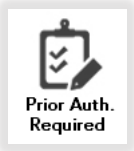
Hearing Aids and the evaluation for the fitting of Hearing Aids are Covered every **36 months** per hearing impaired ear. Coverage is for a Hearing Aid and any related service for the full cost of one Hearing Aid up **$2,200** per hearing-impaired ear for insured children under **18 years old** or under **21 years old** if still attending high school. You may choose a higher priced hearing aid and may pay the difference in cost above the **$2,200** limit. This shall include the fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by an audiologist, a hearing aid dispenser or an In-network Practitioner/Provider licensed in New Mexico.

Electroconvulsive Therapy (ECT)



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

Epidural Injections for Back Pain



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

Family, Infant and Toddler (FIT) Program

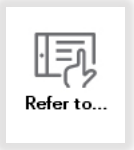
Coverage for children, from birth up to age three under the Family, Infant and Toddler Program (FIT) administered by the Department of Health, provided eligibility criteria are met, is provided for Medically Necessary early intervention services provided as part of an individualized family service plan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

Genetic Inborn Errors of Metabolism Disorders (IEM)

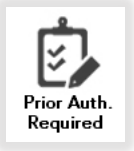
This benefit has one or more exclusions as specified in the **Exclusions Section**.

Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the **Limitations, Exclusions and Prior Authorization** requirements listed in this Agreement. Coverage for the treatment of genetic inborn errors of metabolism are provided with the same Durational limits, caps, deductibles, coinsurance and copayments as any other illnesses. Medical services provided by licensed Healthcare Professionals, including Practitioners/Providers, dieticians and nutritionists with specific training in managing Members diagnosed with IEM are Covered. Covered Services include:

- Nutritional and medical assessment.
- Newborn Screening for Metabolic Diseases.
- Clinical services.
- Biochemical analysis.
- Medical supplies.
- Prescription Drugs/Medications – Refer to **Prescription Drugs/Medications Section**.
- Corrective lenses for conditions related to Genetic Inborn Errors of Metabolism.
- Nutritional management.



- Special Medical Foods are dietary items that are specially processed and prepared to use in the treatment of Genetic Inborn Errors of Metabolism to compensate for the metabolic abnormality and to maintain adequate nutritional status when we approve the **Prior Authorization** request and when provided under the ongoing direction of a qualified and licensed healthcare Practitioner/Provider team. This does not include coverage of nutritional items/food supplements that are available Over-the-counter and/or without prescription.



- Covered within **12 months** after cataract surgery or when related to Genetic Inborn Error of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.

Refer to the pharmacy section of your *Summary of Benefits and Coverage* for applicable Cost-Sharing amounts (office visit Copayments, Inpatient Hospital, Outpatient facility, Prescription Drug/Medications and other related Deductibles, Coinsurance and/or Copayments).

Genetic/Genomic Testing

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

Gym Membership

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

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

Habilitative Services

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

services for people with disabilities in a variety of Inpatient and/or Outpatient settings. There are no quantitative limits for habilitative physical and occupational therapy, speech-language pathology services.

Autism Spectrum Disorder

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

- Diagnosis for the presence of Autism Spectrum Disorder when performed during a Well-Child or Well-baby screening 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 and have no quantitative limitations

Autism Spectrum Disorder Services must be provided by Practitioners/Providers who are certified, registered or licensed to provide these services. There are no annual or lifetime dollar cost limitations/maximums placed on covered ABA services.

Limitation Under the federal Individuals with Disabilities Education Improvement Act (IDEA), the provision of specialized education and related services to children **3 to 22 years of age** for children with a diagnosis of Autism Spectrum Disorder are the responsibility of state and local school boards. Accordingly, specialized education and related services covered under IDEA (services required to be provided through the school system) are not covered Medicaid benefits and therefore not covered under this plan.

Any treatment plan to treat Autism Spectrum Disorder shall include the following elements:

- The diagnosis;
- The proposed treatment by types;
- The frequency and duration of treatment;
- The anticipated outcomes stated as goals;
- The frequency with which the treatment plan will be updated; and
- The signature of the treating physician.

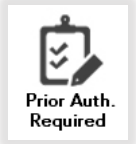
Heart Artery Calcification Scan

Heart Artery Calcification Scans are a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function. These scans are Covered for individuals between the ages of **45-65 years** and that have an intermediate risk of developing coronary heart disease as determined by a healthcare provider based upon a score calculated from an evidence-based algorithm widely used in the medical community to access a persons' **10-year** cardiovascular disease risk, including a score calculated using a pool cohort equation. The scans are Covered only once every **five years** if an eligible Member has previously received

a heart artery calcium score of zero. Coverage will not be provided for future Heart Artery Calcification Scans if an eligible Member receives a Heart Artery Calcium score greater than zero. Heart Artery Calcification is a Covered preventive benefit with no member Cost Sharing.

Home Health Care Services/Home Intravenous Services and Supplies

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



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

Home Health Care Services shall include Medically Necessary skilled intermittent Health Care Services provided by a registered nurse or a licensed practical nurse; physical, occupational, and/or respiratory therapist and/or speech pathologist. Intermittent Home Health aide services are only Covered when part of an approved plan of care which includes skilled services.

Such services may include collection of specimens to be submitted to an approved laboratory facility for analysis.

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

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

- Collection of specimens to be submitted to an approved laboratory facility for analysis.
- Medical equipment, prescription drugs and medications, laboratory services and supplies deemed medically necessary by a Practitioner/Provider for the provision of health services in the home, except durable medical equipment, will be covered.
- Home healthcare or home intravenous services as an alternative to Hospitalization, as determined by your Practitioner/Provider
- Total parenteral and enteral nutrition as the sole source of nutrition
- Medical Drugs (Medications obtained through the medical benefit):
    - A Medical Drug is any drug administered by a Healthcare Professional and is typically given in the member's home, provider's office, freestanding (ambulatory) infusion suite, or Outpatient facility.
    - This includes services rendered in an Outpatient infusion facility where medications or therapies are administered on an Outpatient basis.

- Medical Drugs may require a **Prior Authorization**, and some must be obtained through the specialty network.
- These medications include but not limited to, injectable, infused, oral or inhaled drugs. They may involve unique distribution and may be required to be obtained from the carrier's vendor. Infusion therapy is a benefit covered under this section. There is no difference in Cost Sharing for infusion of medications based on infusion site.
- For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our In-network Specialty network, please see the Presbyterian Pharmacy website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739**.
- You may call our Presbyterian Customer Service Center for more information at **(505) 923-7528** or **1-855-923-7528**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Limitation: The plan may limit this benefit to **100 days** per year.

Home/Durable Medical Equipment

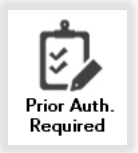
This plan covers equipment that meets the following standards:

- Equipment that is medically necessary for the treatment of an illness or accidental injury or to prevent further deterioration.
- Equipment that is designed for repeated use, including oxygen equipment, functional wheelchairs, and crutches.
- Equipment that is considered standard and/or basic for the treatment of an illness or accidental injury as defined by nationally recognized guidelines.

Hospital Services – Inpatient

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

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



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

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

Inpatient services provided by Out-of-network Practitioners/Providers or facilities are not Covered except as provided in **How This Plan Works, Accidental Injury (Trauma) / Urgent Care / Emergency Health Services / Observation, and Eligibility, Enrollment and Termination and Continuation Sections** of this Agreement.

Inpatient Hospital benefits also include Acute medical detoxification.

Hyperbaric Oxygen Therapy

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

Infertility

Diagnosis and medically indicated treatments for physical conditions causing infertility.

Member Assistance Program

As a Presbyterian Health Plan Member, you and your enrolled dependents have access to a Member Assistance Program (MAP). MAP services include up to three members assistance visits per issue. They are provided by local licensed professionals at The Solutions Group, a division of Presbyterian Healthcare Services. These services, Substance Use Disorder assessments/referrals and other services. Please contact The Solutions Group at **(505) 254-3555** or **1-866-254-3555** if you have any questions regarding MAP covered services and benefits.

Mental Health Services and Alcohol and Substance Use Disorder Services

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

No Cost Sharing For Behavioral Health Services

Cost Sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, Substance Use Disorders and trauma spectrum disorders. This includes Cost Sharing for Inpatient, detoxification, residential treatment and partial hospitalization, intensive Outpatient therapy, Outpatient and prescription drugs that are subject to no Cost Sharing for Behavioral Health Services.

Cost Sharing means any copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

Mental Health and Substance Use Disorder Service Coverage

Your coverage complies with requirements under the federal Mental Health Parity and Addiction Equity Act, and with new sections of the New Mexico Insurance Code Chapter 59A, pursuant to Senate Bill 273, Parity for Coverage of Mental Health and Substance Use Disorder (MH/SUD) Services. For additional information on these requirements or if you feel your rights have been violated, you may contact the NM Office of Superintendent of Insurance using this link: **https://www.osi.state.nm.us/**.

Your rights under these federal and state laws include:

- Generally, coverage in this plan does not impose stricter limitations or financial requirements to MH/SUD coverage than the limitations or financial requirements that are imposed on medical and surgical benefits.
- MH/SUD services that are offered must have treatment available in: psychiatry, psychology, social work, clinical counseling, addiction medicine counseling, and family and marriage counseling. These benefits are subject to network requirements, provider scope of practice and credentialing, and may be subject to medical necessity review.
- Our authorization criteria must follow generally recognized standards of care established by evidence-based resources, including clinical practice guidelines and recommendations from MH/SUD care provider professional associations and relevant federal government agencies.
- Federal and New Mexico law requires the plan not exclude coverage for MH/SUD services under the following circumstances:

- Services that are available to you through federal or state laws for people with disabilities.
- Services that are available to you through a public benefit program.
- Services that have been court ordered and have been determined to be medically necessary by a provider.
- Services for individuals who have co-occurring diagnoses of mental health and Substance Use Disorders.

MH/SUD provider network

- We maintain an adequate network as required by New Mexico state-mandated network adequacy standards of qualified MH/SUD services providers.
- If the eligible services cannot be provided within our network, you will not have to pay extra for eligible services if similar services under your benefit plan are provided by an Out-of-network provider.

Prior Authorization guidelines

- Certain types of services require **Prior Authorization** by us.
  - **Prior Authorization** means that you or your provider must ask us to approve the care before you receive it.
  - **Prior Authorization** cannot be taken back or changed after the provider gives the services in good faith, except for cases of dishonesty, material misrepresentation, or violation of the provider's contract.
  - We are prohibited from ordering **Prior Authorization** or referral for In-network service coverage for: acute or immediately necessary care, acute episodes of chronic MH/SUD conditions, initial In-network Inpatient or Outpatient SUD services.
  - **Prior Authorization** will be determined in discussion with your MH/SUD provider for continuation of services, unless your eligibility in the plan ends.
  - Coverage for medication must be made according to a medical need.
  - For SUD medications, we cannot require **Prior Authorization** or "step-therapy" (such as making you take additional steps before paying for medication prescribed by your provider), unless there is a generic or a biosimilar (which means a biological medicine approved by the FDA that works in a similar way to its reference drug) equivalent.
- After beginning In-network MH/SUD treatment, we may require your provider to notify us and/or develop and submit a treatment plan for continued treatment/services.
- We cannot limit coverage for MH/SUD services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.
- Your length of time for treatment will be based on your provider's recommendation and MH/SUD needs, which may be assessed in conjunction with accepted clinical practice guidelines and recommendations.

Level of care determinations:

- Level of care means the treatment setting or facility type that is most appropriate to treat your condition.
    - Your MH/SUD provider decides, in consultation with the health plan, what types of services you need and for how long, based on your diagnosis and generally recognized standards of care.
    - Services may include placement into a facility that provides detoxification services, a hospital, an in-patient rehabilitation treatment facility or Outpatient treatment program.
    - Changes in level and length of time of care will be determined by your provider in consultation with the health plan and based on assessments of medical necessity using accepted clinical practice guidelines.
- At your request, we will provide coordination of care which means we may help communication between your MH/SUD service provider and your primary care provider to prevent any conflicts of care that could be harmful to you.
- We will make sure our MH/SUD policies are available to you.
- We protect your confidentiality when receiving MH/SUD treatment.
- We will not end coverage of your treatment without a discussion with your MH/SUD provider and you.
- If your claim is denied due to lack of "medical necessity," you have a right to request the specific reasons for your denial.

Mental Health Services

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

When In-network access to mental health or Substance Use Disorder services are not reasonably available, Presbyterian will provide access to Out-of-network services with the same Cost-Sharing obligations as those required for In-network services.

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

Coverage for mental health or Substance Use Disorder services is otherwise included when:

- It is available pursuant to federal or state law for individuals with disabilities;
- It is otherwise ordered by a court or administrative agency;
- It is available to an enrollee through a public benefit program; or
- An enrollee has a concurrent diagnosis.

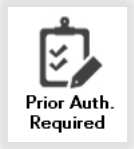
Changes in level and duration of care will be determined by the member's provider in consultation with the member. Level of care determinations may include placement into a facility that provides detoxification services, a hospital, an Inpatient rehabilitation treatment facility or an Outpatient treatment program.

At the members request, Presbyterian may facilitate communication between mental health or Substance Use Disorder services providers and the member's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the insured.

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

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

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



Acute medical detoxification benefits are Covered under Inpatient and Outpatient Medical services found in the Benefits Section of this Agreement and will cover no less than **30 days** in an alcohol dependency treatment center and no less than **30 Outpatient** visits for alcohol dependency treatment. Some services require **Prior Authorization** except when requesting emergency services.

Alcohol and Substance Use Disorder Services

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

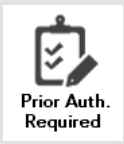
For Out-of-network Services, Members need to contact our Behavioral Health Department in order to obtain **Prior Authorization**, when required. Please refer to the **Prior Authorization Section**.

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

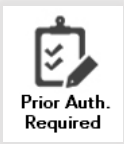
Acute Medical Detoxification Benefits are Covered under Inpatient and Outpatient Hospital Services found in the Benefits Section of this Agreement and will cover no less than **30 days** in an alcohol dependency treatment center and no less than **30 Outpatient** visits for alcohol dependency treatment.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

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

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



Nonemergency care when traveling outside the U.S.

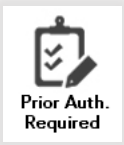


Nonemergency care when traveling outside the U.S. requires **Prior Authorization**

Nutritional Support and Supplements

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

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

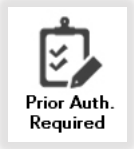


Nutritional supplements that require a prescription to be dispensed are Covered when prescribed by an In-network Practitioner/Provider and when Medically Necessary to replace a specific documented deficiency. **Prior Authorization is required.**

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

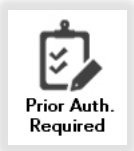
Enteral formulas or products, as Nutritional support, are Covered only when prescribed by an In-network Practitioner/Provider and administered.

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



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

Custom Orthotics

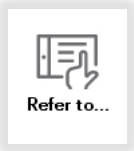


Some Prefabricated Orthotics require **Prior Authorization**.

Outpatient Medical Services

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

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



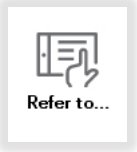
Outpatient Medical services include reasonable Hospital services provided on an ambulatory (Outpatient) basis and those preventive, Medically Necessary diagnostic and treatment procedures that are prescribed by your In-network Practitioner/Provider. Refer to the **Prior Authorization Section** for services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

Facility fees are determined by the facility providing the service. Members can inquire from the facility what the charge would be prior to receiving service and they can also receive an estimate for the cost of the service by using Presbyterian's treatment cost estimator tool. If a member receives unexpected charges, member should refer to their surprise billing rights in the member handbook and their explanation of benefits if it's determined to be a surprise billing charge.

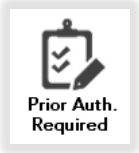
Outpatient services provided by Out-of-network Providers/Practitioners are not Covered except as provided in **How the Plan Works, Eligibility and Enrollment, and Accidental Injury (Trauma) / Urgent Care / Emergency Health Services / Observation Benefit Sections**.

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

- Chemotherapy and radiation therapy – Chemotherapy is the use of chemical agents in the treatment or control of disease.
- Hypnotherapy (Limited) – Hypnotherapy is only Covered when performed by an anesthesiologist or psychiatrist, trained in the use of hypnosis when: Used within two weeks prior to surgery for chronic pain management and for chronic pain management when part of a coordinated treatment plan.
- Dialysis.
- Diagnostic Services – Refer to the **Diagnostic Services Section**.
- Medical Drugs (Medications obtained through the medical benefit).
    - A Medical Drug is any drug administered by a Health Care Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or Outpatient facility. Medical Drugs may require a **Prior Authorization**, and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our Specialty network, please see the Presbyterian Pharmacy website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739**. These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in your *Summary of Benefits and Coverage*.
- Observation following Outpatient Services.
- Sleep disorder studies, in home or Outpatient facility (sleep studies done in a facility require **Prior Authorization**).
- Surgery.
- Therapeutic and support care services, supplies, appliances and therapies.
- Wound care.
- Facilities fees



Positron Emission Tomography (PET) scans in an Outpatient setting



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

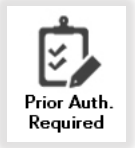
Practitioner/Provider Services

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

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

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

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



- Office visits provided by a qualified Practitioner/Provider.
- Virtual Care provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters. PHP Video Visits utilizes a nationwide network of Providers.
- Behavioral health services will be provided via telemedicine on the same terms as physical health services in compliance with the telemedicine parity and mental health parity laws.
- Outpatient surgery and Inpatient surgery including necessary anesthesia services. Anesthesia may include hypnotherapy.
- FDA-approved contraceptive devices and prescription drugs as described on the drug *Formulary*.
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care.
- Coverage for allergy testing and treatment.
- Sterilization procedures.
- Student Health Centers: Dependent Students attending school either in New Mexico or outside New Mexico may receive care through their PCP or at the Student Health Center. A **Prior Authorization** is not needed prior to receiving care from the Student Health Center. Services provided outside of the Student Health Center are limited to Medically Necessary Covered services for the initial care or treatment of an Emergency Healthcare Service or Urgent Care situation.

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

Prescription Drugs/Medications

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

Covered Prescription Drugs/Medications

Prescription Drug/Medications Benefit (Outpatient)

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

For a complete list of these drugs, please see the Health Insurance Exchange Metal Level Plan *Formulary* list at **https://client.formularynavigator.com/Search.aspx?siteCode=0324498195**.

Affordable Care Act (ACA)

In accordance with the Affordable Care Act (ACA), we will provide evidence-based Preventive Drug coverage as identified by the United States Preventive Services Task Force (USPSTF). These recommendations are meant to help prevent certain health conditions for adults, women, and children. You may receive these services from our In-network Practitioners/Providers, without imposing a copayment, coinsurance or deductible regardless of sex assigned at birth, gender identity, or gender of the individual.

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

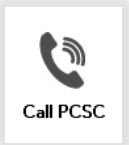
ACA Preventive Drug categories include the following: Aspirin, Bowel Preparation, Breast Cancer Primary Prevention, Contraceptives, Fluoride, Folic Acid Supplements, HIV Pre-Exposure Prophylaxis (PrEP), Iron Supplements, Single Agent Statins, Tobacco Cessation, and Vaccines.

Tobacco Cessation Treatments

The following preventive medications and products for Tobacco cessation treatments may be available with no Cost Sharing: Nicotine gum, Nicotine patches, Nicotine lozenges, Nicotine oral or nasal spray, Nicotine inhaler, bupropion, and Chantix (varenicline).

Visit the *Formulary* listing at
https://client.formularynavigator.com/Search.aspx?siteCode=0324498195.

Preventive medications will be listed as **$0** Copay per PPACA. For preventive medications (including over-the-counter medications) or products to be Covered, a pharmacy claim will need to be submitted. Present your ID card to the dispensing pharmacy for processing and billing information.



You can contact our Presbyterian Customer Service Center from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. **TTY** users may call **711**.

Contraception Coverage

You are entitled to receive certain covered contraception services and supplies without Cost Sharing and without **Prior Authorization** from us. This means that you do not have to make a copayment, coinsurance, satisfy a deductible or pay Out-of-pocket for any part of contraception benefits listed in this summary if you receive them from an In-network Provider. You may be required to pay a copay, coinsurance, and/or a deductible if you receive a contraception service or supply from an Out-of-network Provider if the same service or supply is available In-network.

Methods of preferred generic oral contraceptives, injectable contraceptives, or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at **https://client.formularynavigator.com/Search.aspx?siteCode=0045707827**.

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

Covered Contraceptive Methods

Your plan covers these contraceptive methods:

- Sterilization Surgery for Women
- Sterilization Surgery for Men
- IUD Copper
- IUD with Progestin
- Implantable Rod
- Shot/Injection
- Oral Contraceptives (The Pill) (Combined Pill)
- Oral Contraceptives (Extended/Continuous Use)
- Oral Contraceptives (Mini Pill – Progestin Only)
- Patch

- Vaginal Contraceptive Ring
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Male Condom
- Female Condom
- Spermicide
- Emergency Contraceptive

Long-Acting Reversible Contraceptives

The long-acting reversible contraceptives (LARCs), including Intrauterine Devices (IUDs) covered without Cost Sharing are listed here: **https://client.formularynavigator.com/Search.aspx?siteCode=0045707827**. Coverage with no Cost Sharing also applies to IUD insertion and removal, including surgical removal, and to any related medical examination when services are obtained from an In-network Provider. Coverage of LARCs with no Cost Sharing also includes (predischarge) postpartum clinical services.

Six-Month Dispensing

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

Brand Name Drugs or Devices

Your plan may exclude or apply Cost Sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Refer to the list of contraceptive methods above. Ask your Provider about a possible equivalent. If your Provider determines that a brand-name contraceptive is medically necessary, your Provider may ask us to cover that contraceptive without Cost Sharing. If we deny the request, you or your Provider can submit a grievance to contest that denial.

Vasectomies and Male Condoms

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

Sexually Transmitted Infections (STIs)

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

Coverage for Contraception Where a Prescription Is Not Required

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

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

Address: Presbyterian Health Plan
Attn.: Pharmacy Dept.
P.O. Box 27489
Albuquerque, NM 87125-7489

Email: **askpharmacy@phs.org**

Fax: **(505) 923-5540**

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

Availability of Out-of-network Coverage

Under your plan, use of an Out-of-network Provider to prescribe or dispense contraceptive coverage is a Covered benefit. Please refer to the Prescription drug coverage section *Summary of Benefits and Coverage* to learn more about your Out-of-network benefit.

What is a Formulary?

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

The primary purpose of the *Formulary* is to encourage the use of safe, effective and most affordable medications. Presbyterian Health Plan administers a closed *Formulary*, which means that Non-*Formulary* drugs are not routinely reimbursed by the plan. Medical exception policies provide access to Non-*Formulary* medication when Medical necessity is established. The medications listed on the *Formulary* are subject to change pursuant to the management activities of Presbyterian Health Plan. For the most up-to-date *Formulary* drug information visit **https://client.formularynavigator.com/Search.aspx?siteCode=0324498195**.

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

Can the Formulary change during the year?

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

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

If we remove drugs from our *Formulary*, add or modify coverage criteria for **Prior Authorization** or step-therapy, modify or add quantity limits, impose or modify coverage restrictions on a drug, move a drug to a higher tier, or reclassify a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the *Formulary*, advanced written notice will be sent to affected members of the change at least **60 days** before the change becomes effective.

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

- Reclassify a drug from preferred to a non-preferred tier of the *Formulary*.
- Reclassify a drug from a preferred classification to a non-preferred classification, unless that Reclassification results in the drug moving to a lower tier of the *Formulary*.
- Increase the Cost Sharing, copayment, deductible or coinsurance charges for a drug.
- Remove a drug from the *Formulary*.
- Establish a **Prior Authorization** requirement.
- Impose or modify a drug's quantity limit; or
- Impose a step-therapy restriction.

How is the Formulary Drug List Developed?

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

The P&T Committee meets quarterly to promote the appropriate use of drugs, to maintain the Presbyterian formularies, and to support our network of practitioners. Medications chosen for the *Formulary* are selected based on their safety, effectiveness and overall value. A medication may not be added to the *Formulary* if current drugs on the *Formulary* are equally safe and effective and are less costly.

The Presbyterian *Formulary* provides essential health benefits with coverage of:

- One drug in every United States Pharmacopeia (USP) category and class; or
- The same number of prescription drugs in each category and class as the essential health benefits-benchmark plan.

Utilization management strategies such as quantity limits, step-therapy and **Prior Authorization** criteria are reviewed and approved by the P&T committee.

Presbyterian conducts nonquantitative treatment limitations (NQTLs) analyses of its fully insured benefit plans, regulated by the New Mexico Office of Superintendent of Insurance (OSI). The comparative analyses are developed to comply with the NQTL analysis and documentation requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by Section 203 of the Consolidated Appropriations Act of 2021.

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

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

Drug Recalls

A drug recall may occur when a prescription drug is removed from the market because it is found to be defective or potentially harmful product. A recall is a voluntary action taken by the manufacturer to remove a defective drug product from the market or warn patients about a potential risk. An insurer may immediately and without prior notice remove a drug from the *Formulary* if the drug:

- Is deemed unsafe by the federal food and drug administration; or
- Has been removed from the market for any reason.

Class I Drug Recall – A situation whereby a reasonable probability exists that the use of, or exposure to a product will cause serious adverse health consequences or death.

Class II Drug Recall – A situation whereby use of, or exposure to a product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Class III Drug Recall – A situation in which use of, or exposure to a product is not likely to cause adverse health consequences.

Members and prescribing practitioners affected by a Class II or Class III drug recall or voluntary market withdrawal of a drug will be identified and notified in writing via the United States Postal Service (USPS) within **30 calendar days** of the FDA notification. Supplemental provider communications (e.g., newsletter article) will also be distributed to Members and prescribing practitioners affected by a Class I drug recall will be identified and notified via USPS and one other communication mode attempt (i.e., telephone, fax and/or email) as soon as feasible after the FDA notification.

What is Prior Authorization?

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

Prescription drug Prior Authorization protocols

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

- No later than **24 months** after the adoption of national standards for electronic **Prior Authorization**, a health insurer shall exchange **Prior Authorization** requests with providers who have e-prescribing capability.
- If a healthcare plan fails to use or accept the uniform **Prior Authorization** form or fails to respond within **three business days** upon receipt of a uniform **Prior Authorization** form, the **Prior Authorization** request shall be deemed to have been granted.
- As used in this section, "healthcare plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make healthcare expense payments but does not include:
    - A person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income; a physician or a physician group to which a healthcare plan has delegated financial risk for prescription

drugs and that does not use a **Prior Authorization** process for prescription drugs; or

- A healthcare plan or its affiliated providers, if the healthcare plan owns and operates its pharmacies and does not use a **Prior Authorization** process.

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

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

Prior Authorization will not be required for:

- FDA indicated Substance Use Disorder medications except when a generic version is available. In such instances medical necessity must be established to receive the brand name medication.

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

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

What is Step-Therapy?

Step-therapy promotes the appropriate use of equally effective but lower-cost *Formulary* drugs first. With this program, prior use of one or more "prerequisite" drugs is required before a step-therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step-therapy drugs. Prescription drug coverage specific to step-therapy protocols will be followed pursuant to 59A-22B-8.

Step-Therapy Exception

We will grant an exception to our step-therapy protocol if your prescribing provider determines that the prescribed drug should not be substituted for a therapeutic equivalent. The provider must submit to us a clinically valid explanation. We will not require a substitution if:

- The prescription drug for which you're requesting an exception is contraindicated or will likely cause an adverse reaction or cause you physical or mental harm;
- The prescription drug for which you're requesting an exception is expected to be ineffective based on your known clinical characteristics and the known characteristics of the prescription drug regimen;
- You have tried the prescription drug for which you're requesting an exception or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or
- The prescription drug required pursuant to the step-therapy protocol is not in your best interest, based on clinical appropriateness, if your use of the drug is expected to:
    - Make it difficult for you to comply with the plan of care;
    - Worsen a comorbid condition; or
    - Decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

Upon granting an exception, we will authorize coverage for the prescription drug that is the subject of the exception request for no less than the duration of the therapeutic effect of the drug. Additionally, you are not required to submit any additional exception requests for that prescription drug, when medication adherence is established.

We will respond with our decision on an exception request within **72 hours** of receipt. In urgent cases, we will respond within **24 hours** of receipt of the exception request. If we do not respond to an exception request within the time frames above, the exception request shall be granted.

Step-therapy will not be required for:

- Substance Use Disorder medications are not subject to step-therapy protocols except when a generic version is available. In such instances medical necessity must be established to receive the brand name medication.

What are Quantity Limits?

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

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

Non-Extended Day Supply

Presbyterian has established protocols under the guidance of National Committee for Quality Assurance (NCQA) in an effort to ensure patients' safety for prescription drugs. Pursuant to this guidance, Presbyterian has limited the maximum allowed day supply down to **30 days** at a time for medications that fall into this high-risk category. If a dispensing limit is applied to *Formulary* drugs they will be identified on the *Formulary* as Non-Extended Day Supplies (NEDS). If your doctor prescribes a greater quantity of medication than what the dispensing limit allows, you can still get the medication. However, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Biologic Medications

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

Daily Cost Sharing

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

Drug Refill dispensing limits

Refills of a Prescription Drug will not be covered until the Member is reasonably due for a refill as calculated based upon the Prescription Drug being taken at the prescribed dosage and appropriate intervals and when the number of days' supply the member has remaining on hand does not exceed the dispensing limits.

Eye Drop Renewal

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

Insulin for Diabetes Cost-Sharing Cap

The Copayment amount for a preferred *Formulary* prescription insulin drug or a Medically Necessary alternative will be Covered at an amount not to exceed a total of **$25** per **30-day** supply.

Medication Synchronization

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

No Behavioral Health Cost Sharing

A prescription drug covered on the plan's drug *Formulary* or authorized by the plan when the drug is in a USP therapeutic category and class combination used for the treatment of mental illness, behavioral health, or Substance Use Disorders when are covered at no Cost Share. Coverage at no Cost Share is subject applicable benefit plans and behavioral health conditions subject to House Bill 292 with the exception of the following:

- F01.x – F09.9x - Mental disorders due to known physiological conditions
- F70.x – F79.9x - Mild intellectual disabilities
- F80.x – F83.9x - Pervasive and specific developmental disorders
- F85.x – F89.9x - Pervasive and specific developmental disorders
- F91.x – F98.9x - Behavioral and emotional disorders with onset usually occurring in childhood and adolescence.

Refer to the *Formulary* listing at **https://client.formularynavigator.com/Search.aspx?siteCode=0324498195** for additional coverage details.

Orally Administered Anti-Cancer Medications

This Plan provides coverage for orally administered anti-cancer medication used to slow or kill the growth of cancerous cells. Coverage of these medications are subject to the same **Prior Authorization** requirements as intravenously administered injected cancer medications Covered by the Plan. Orally administered mediations cannot cost more than an intravenously injected

equivalent. Intravenously injected medications cannot cost more than orally administered medications.

Rebates

Some medications may qualify for prescription rebates which could lower your Out-of-pocket costs for those products. For any such medication where prescription rebates apply, the Member shall receive credit towards their maximum Out-of-pocket after applicable deductible is met.

Third Party Payment

The plan accepts Cost-Sharing accumulation for any third-party payment (such as a drug manufacturer's coupon or copay assistance program) and that the rebated amount will count towards the insured's Cost Sharing.

An enrollee who uses direct support offered by drug manufacturers for specific prescription drugs will have the value of the support counted toward Maximum Out-of-pocket Limit.

Drug Utilization Review and Drug use evaluation programs

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

Generic Drugs

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

Brand-Name Drugs When a Generic Equivalent is Available

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

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

What if my Drug is not Covered?

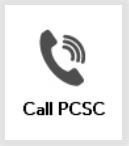
You or your doctor can ask us to make an exception (**Prior Authorization**) to our coverage rules. We will work with your prescriber to get additional information to support your request.

Coverage of a drug includes medically necessary services associated with the administration of the drug provided that such services would not be otherwise excluded from Coverage 13.10.13.10.

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

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

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



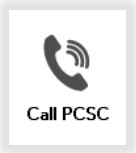
For more information, contact our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call our **TTY** line at **711.**

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

Covering a drug for you that is not on our Formulary

- If we agree to cover a drug not on the *Formulary*, you will need to pay the Cost-Sharing amount that applies to drugs on the Specialty Drug Tier.

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



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

Benefit Limitations

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

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

Presbyterian will not require an enrollee to make a payment at the point of sale for a covered prescription drug in an amount greater than:

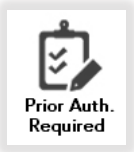
- Applicable Cost-Sharing amount for the prescription drug;
- Amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription
- Drug benefits or discounts;
- Total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the Cost-Sharing amount paid by an insurer; or
- Value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

For purposes of this section, “Cost Sharing” means any of the following:

- Copayment;
- Coinsurance;
- Deductible;
- Out-of-pocket Maximum;
- Other financial obligation, other than a premium or share of a premium; or
- Combination thereof.

Pursuant to 59A-46-52.3, Coupon accumulators, calculating an enrollee’s Cost-Sharing obligation for prescription drug coverage.

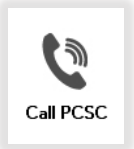
Self-Administered Specialty Pharmaceuticals



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

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

For a complete list of these drugs and *Formulary* coverage, please see the Specialty Pharmaceutical listing at **http://docs.phs.org/idc/groups/public/documents/communication/pel_00236101.pdf**.



For Specialty Pharmacy information please see the pharmacy services available at **https://www.phs.org/doctors-services/supporting-services/pharmacy-services**. You can call our Presbyterian Customer Service Center for additional information about the Presbyterian Specialty Pharmacy network, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528.** Hearing impaired users may call **TTY 711**.

Office Administered Specialty Pharmaceuticals (Medical Drugs)

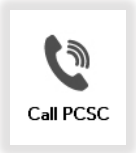
A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or Outpatient facility. Medical Drugs may require a **Prior Authorization,** and some must be obtained through the specialty network. These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in your Prescriptions drug coverage section of your *Summary of Benefits and Coverage*.

For a complete list of Medical Drugs to determine which require **Prior Authorization**, please see the Presbyterian Pharmacy website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739**.

Mail-Order Pharmacy

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

purchased by mail order, such as Self-Administered Specialty Pharmaceuticals or Non-Extended Day Supply drugs with dispensing limits.



You may obtain more information on the Mail-Order Pharmacy by calling our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

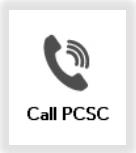
Member Reimbursement

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

A reimbursement request that is transmitted electronically, via email or fax, pursuant to the insurer's instructions, is deemed received by the insurer on the date of receipt, unless the covered person receives notice of a transmission error.

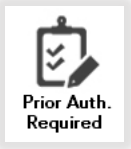
The following information is needed to determine reimbursement amounts. Please submit a *Prescription Drug Reimbursement Form* and attach the itemized cash register receipt and the prescription drug detail (pharmacy pamphlet) along with the following information:

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



Please see the Presbyterian Pharmacy website at **https://www.phs.org/tools-resources/member/pharmacy** to obtain a form or call our Presbyterian Customer Service Center at **(505) 923-7324** or **1-855-593-7737**, Monday through Friday from 7 a.m. to 6 p.m.

Proton Beam Irradiation



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

Reconstructive Surgery

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

Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be Covered if performed for the correction of functional disorders. This surgery is covered if performed as medically necessary. The following reconstructive surgery benefits are covered:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery.
- Reconstructive surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.
    - For information regarding Reconstructive Surgery following a Mastectomy and Prophylactic Mastectomy, refer to the **Women's Healthcare Section**.

Rehabilitation and Therapy

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

Cardiac Rehabilitation Services

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

Pulmonary Rehabilitation Services

Pulmonary Rehabilitation benefits are available for progressive exercises and monitoring of pulmonary functions. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost-Sharing amount.

Short-term Rehabilitation Services

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

- Presbyterian will not impose a member Cost Share for physical rehabilitation and Chiropractic services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applicable or if a copay is applicable. The physical rehabilitation services must be performed by, or under the direction of a licensed physical therapist, occupational therapist or speech therapist. The Chiropractic services must be performed by a Chiropractic physician.
- Outpatient physical and occupational therapy require that your Primary Care Practitioner or other appropriate treating Practitioner/Provider must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in your condition. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost-Sharing amount. The treatment plans that define expected Significant Improvement must be established at the initial visit. Therapy treatments must be provided and/or directed by a licensed physical or occupational therapist.
- Treatments by a physical or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist.
- Massage Therapy is only Covered when provided by a licensed physical therapist and as part of a prescribed Short-term Rehabilitation physical therapy program. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost-Sharing amount.

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

Limitations

Your PCP must determine, in advance, in consultation with us, that speech therapy can be expected to result in Significant Improvement in your condition. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost-Sharing amount.

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

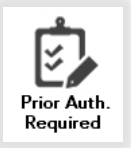
Selected Surgical/Diagnostic Procedures

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

- Bariatric Surgery
- Blepharoplasty/Brow Ptosis Surgery
- Breast Reconstruction following Mastectomy
- Breast reduction for gynecomastia
- Cholecystectomy by Laparoscopy
- Endoscopy Nasal/Sinus balloon dilation
- Hysterectomy
- Lumbar/Cervical Spine Surgery
- Major endoscopic procedures
- Meniscus Implant and Allograft/Meniscus Transplant
- Operative and cutting procedures
- Panniculectomy
- Preoperative and postoperative care.
- Rhinoplasty
- Tonsillectomy
- Total Ankle Replacement
- Total Hip Replacement
- Total Knee Replacement

Skilled Nursing Facility Care

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



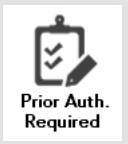
Room and board and other necessary services furnished by a Skilled Nursing Facility are Covered and require **Prior Authorization**. Admission must be appropriate for your Medically Necessary care and rehabilitation.

Refer to the skilled nursing section of your *Summary of Benefits and Coverage* for your visit limitations.

Sleep Studies

Home sleep studies are Covered In-network without a **Prior Authorization**. In-facility sleep studies are covered In-network with a **Prior Authorization** if medical necessity criteria is met. Treatment for Obstructive Sleep Apnea, including oral appliances, CPAP (Continuous Positive Airway Pressure), BiPAP (Bilevel Positive Airway Pressure), and hypoglossal nerve stimulators are covered with a **Prior Authorization** if medical necessity criteria met.

Special Inpatient services (including but not limited to private room and board and/or special duty nursing)



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

Telemedicine Services

PHP provides coverage for telemedicine services, also known as virtual care, to the same extent that this agreement covers the same services when provided in person. PHP will not impose originating-site restrictions. Coverage maybe extended to Out-of-network Providers in instances where no In-network Provider is accessible, as defined by network adequacy standards. A determination by PHP that services delivered through the use of telemedicine are not Covered is subject to review and appeal.

This Benefit includes, but not limited to, consultation and Healthcare Services and supplies

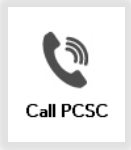
- Virtual visits provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters. Virtual care utilizes a nationwide network of Providers.
- Behavioral health services will be provided via telemedicine on the same terms as physical health services in compliance with the telemedicine parity and mental health parity laws

Tobacco Cessation Counseling/Program

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

Coverage is provided for Diagnostic Services, Tobacco Cessation Counseling and pharmacotherapy. Medical services are provided by licensed Health Care Professionals with specific training in managing your Tobacco Cessation Program. The program is described as follows:

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

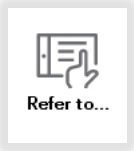


For more information, please contact our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Pharmacotherapy benefit Limitations

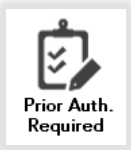
- Prescription Drugs/Medications purchased at an In-network Pharmacy
- Two **90-day** courses of treatment per Contract Year

Refer to the pharmacy section of your *Summary of Benefits and Coverage* and your *Formulary* for your Cost-Sharing amount.



Transplants

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



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

Coverage for organ transplantation or associated care to a member will not be denied solely on the basis of that person's physical or mental disability. Additionally, coverage for organ transplantation or associated care will not be reduced or limited for a member with a physical or mental disability for associated care related to organ transplantation as determined in consultation with the physician and member.

Human Solid Organ transplant benefits are Covered for:

- Kidney
- Liver
- Pancreas
- Intestine
- Heart
- Lung
- Multi-visceral (three or more abdominal Organs)
- Simultaneous multi-Organ transplants – unless investigational
- Pancreas islet cell infusion
- Meniscal Allograft
- Autologous Chondrocyte Implantation – knee only
- Hematopoietic Transplant Benefits are Covered for:
    - Bone Marrow Transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are Covered for the following indications:
        - Multiple myeloma
        - Leukemia
        - Aplastic anemia
        - Lymphoma
        - Severe combined immunodeficiency disease (SCID)
        - Wiskott Aldrich syndrome
        - Ewing's Sarcoma
        - Germ cell tumor
        - Neuroblastoma
        - Wilms Tumor
        - Myelodysplastic Syndrome
        - Myelofibrosis
        - Sickle cell disease
        - Thalassemia major

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

Limited travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be Covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be Covered for both out-of-state and instate, up to a maximum of

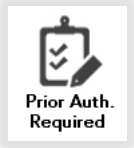
$150 per day for the transplant recipient, live donor and one other person combined. All Organ transplants must be performed at site that we approve and require **Prior Authorization**.

Vision for Children

Individual Plan Members up to **age 19** are eligible for Presbyterian Vision for Children benefits. These benefits include vision care as part of your enrollment in a Presbyterian Individual Plan. Please see the Presbyterian vision flyers attached to the end of this Subscriber Agreement.

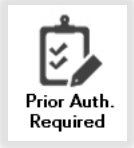
Weight Loss Program

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



Dietary evaluations and counseling for the medical management of morbid obesity and obesity. Prescription drugs medically necessary for the treatment of obesity and morbid obesity are also covered. For a complete list of these drugs, please see the Health Insurance Exchange Metal Level Plan *Formulary* list at **https://client.formularynavigator.com/Search.aspx?siteCode=0324498195**. See also, benefits described under **Bariatric Surgery**. This procedure requires **Prior Authorization**.

Wireless Capsule Endoscopy



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

Women's Healthcare

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

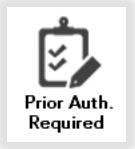
Gynecological care includes:

- Annual exams
- Care related to pregnancy
- Miscarriage

- Therapeutic abortions
- Elective abortions up to **24 weeks**
- Other gynecological services

Prenatal Maternity care benefits include:

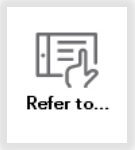
- Prenatal care
- Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between **16 and 20 weeks** of pregnancy, to screen for certain abnormalities in the fetus)
- Visits to an Obstetrician
- Certified Nurse-midwife
- Licensed Midwife
- Medically Necessary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



Maternity Care

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

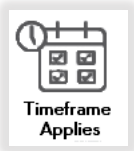
- Maternity Coverage is available to a mother and her newborn (if a Member) for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a cesarean section. Maternity Inpatient Hospital admissions and birthing center admissions require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



- The services of a Licensed Midwife or Certified Nurse Midwife are Covered, for the following:
    - The midwife's services must be provided strictly according to their legal scope of practice and in accordance with all applicable state licensing regulations which may include a supervisory component.
    - The services must be provided in preparation for or in connection with the delivery of a newborn.
    - For purpose of Coverage under this Agreement, the only allowable sites of delivery are a Hospital or a licensed birthing center. Elective Home Births and any prenatal or postpartum services connected with Elective Home Births are not Covered. Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.
    - The combined fees of the midwife and any attending or supervising Practitioners/Providers, for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Practitioner/Provider had they have been the sole Practitioner/Provider of those services.
    - Ultrasounds related to maternity care. Ultrasounds do not require **Prior Authorization**.

Newborn Care

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

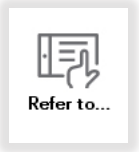


- Your newborn or the newborn of your Spouse will be Covered from the moment of birth if we receive the signed and completed Qualifying Event Form within **60 days** from the date of birth.
- If the Qualifying Event Form is not received within **60 days** of the birth, then the newborn is not eligible for family coverage.
- If the above conditions are not met, we will not enroll the newborn for Coverage until the next Annual Enrollment Period.
- Neonatal care is available for the newborn of a Member for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a Cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, it is considered a separate Hospital stay and requires **Prior Authorization**. Refer to the maternity section of your *Summary of Benefits and Coverage* for your Cost-Sharing amount.
- Benefits for a newborn who is a Member shall include Coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Where necessary to protect the life of the infant Coverage includes transportation, including air Ambulance Services to the nearest available Tertiary facility. Newborn Member benefits also include Coverage for newborn visits in the Hospital by the baby's Practitioner/Provider, circumcision, incubator, and routine Hospital nursery charges.

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

Additional Women's Health Care Benefits

- Mammography and Diagnostic Mammography Coverage.
- Mastectomy, Prophylactic Mastectomy, Prosthetic Devices and Reconstructive surgery. Some care requires **Prior Authorization**.
    - Coverage for Medically Necessary surgical removal of the breast (mastectomy) is for not less than **48 hours** of Inpatient care following a mastectomy and not less than **24 hours** of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless you and the attending Practitioner/Provider determine that a shorter period of Hospital stay is appropriate.
    - Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer is subject to Cost-Sharing amounts consistent with those imposed on other benefits. Refer to the Inpatient stay section of your *Summary of Benefits and Coverage* for Cost-Sharing amounts.

    - Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). Two bras per year are Covered for Members with external breast prosthesis.
    - As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.
    - Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy.
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- The Alpha-fetoprotein IV screening test for pregnant women, generally between 16 and **20 weeks** for pregnancy, to screen for certain genetic abnormalities in the fetus.
- Non-Invasive Prenatal Testing (NIPT) (may require **Prior Authorization**).
- Coverage for the preventive screening of women who have family members with breast, ovarian, tubal or peritoneal cancers with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2) (may require **Prior Authorization**).
- Women with positive screening results may receive genetic counseling and, if indicated after counseling, BRCA testing as determined by her healthcare provider (may require **Prior Authorization**).

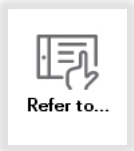
General Limitations

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

Benefit Limitations

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

- Some Benefits may be subject to dollar amount and/or visit limitations.
- Some services or procedures, such as anesthesia, may be billed separately and may incur separate Cost Sharing.
- Benefits may be excluded if the services are provided by Out-of-network Practitioners/Providers.
- Some Benefits may be subject to **Prior Authorization**.



Refer to your *Summary of Benefits and Coverage* and the **Benefits Section** for details about these limitations.

Coverage while away from the Service Area

When you are away from the Service Area, Covered Benefits are limited to Emergency Health Care Services and Urgent Care.

Major Disasters

In the event of any major disaster, epidemic or other circumstances beyond our control, we shall render or attempt to arrange Covered Benefits with In-network Practitioners/Providers insofar as practical, according to our best judgment, and within the limitations of facilities and personnel as are then available. However, no liability or obligation shall result from nor shall be incurred for the delay or failure to provide any such service due to the lack of available facilities or personnel if such lack is the result of such disaster, epidemic or other circumstances beyond our control, and if we have made a good-faith effort to provide or arrange for the provision of such services. Such circumstances include complete or partial disruption of facilities, war, act(s) of terrorism, riot, civil insurrection, disability of a significant part of a Hospital, our personnel or In-network Practitioners/Providers or similar causes.

Prior Authorization

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

Exclusions

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

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

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

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

Ambulance Services

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

Autopsies

Autopsy costs for Covered Members are not Covered.

Before or After the Effective Date of Coverage

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

Cancer or Other Life-Threatening Medical Condition Clinical Trials

Not Covered

- Costs of the clinical trial that are customarily paid for by the government, biochemical, pharmaceutical, or medical device industry sources
- The cost of a non-FDA approved investigational drug, device, or procedure
- The cost of a non-healthcare service the patient is required to receive as a result of participation in the clinical trial
- Costs 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 for or not charged by the clinical trial providers

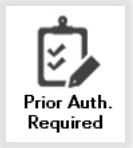
Care for Military Service-Connected Disabilities

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

Certified Hospice Care Benefits

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

- Food, housing, and delivered meals are not Covered.
- Volunteer services are not Covered.
- Personal or comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits) are not Covered.
- Homemaker and housekeeping services are not Covered.
- Private duty nursing is not Covered.
- Pastoral and spiritual counseling are not Covered.
- Bereavement counseling is not Covered.
- The following services are not Covered under Hospice care, but may be **Covered Benefits elsewhere in this Agreement** subject to the Cost-Sharing requirements:
    - Acute Inpatient Hospital care for curative services – requires **Prior Authorization**.
    - Durable Medical Equipment.
    - Practitioner/Provider visits by other than a Certified Hospice Practitioner/Provider.
    - Ambulance Services.



Charges in Excess of Medicare Allowable Unreasonable

Charges that we determine to be in excess of Medicare Allowable Charges and charges we determine to be unreasonable are not Covered.

Clinical Preventive Health Services

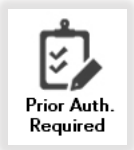
Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to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

Immunizations for the purpose of foreign travel are not Covered.

Clinical Trials

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

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



Services from Out-of-network Practitioners/Providers, unless services from an In-network Practitioner/Provider is not available and are not Covered. **Prior Authorization** is required for any Out-of-network Services and such services must be provided for in New Mexico, unless in urgent or emergent situations as defined by your plan.

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

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

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

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

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

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

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

Clothing or Other Protective Devices

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

Complementary Therapies

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

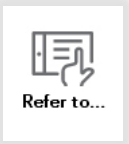
- **Acupuncture** – Except as specified under Complementary Therapies in the Benefits Section.
- **Chiropractic Services** – Except as specified under Complementary Therapies in the Benefits Section.
- **Biofeedback** – Except as specified under Complementary Therapies in the Benefits Section.

Cosmetic Surgery

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

This plan does not cover cosmetic surgery, services, or procedures to change family characteristics or conditions caused by aging. This plan excludes coverage for cosmetic surgery or services for psychiatric or psychological reasons. This plan does not cover services related to or required as a result of a cosmetic service, procedure, surgery or subsequent procedures to correct unsatisfactory cosmetic results attained during an initial surgery.

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



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

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

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

Costs for Extended Warranties and Premiums for Other Insurance Coverage

Costs for extended warranties for services or devices provided under this plan (i.e., Durable Medical Equipment warranties), and premiums for other insurance coverage are not Covered.

Counseling and Education Services

Not Covered: Your benefits do not include:

- Coverage for bereavement, pastoral/spiritual and sexual counseling;
- Psychological testing when not medically necessary;
- Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems;
- Court ordered evaluation or treatment, treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy; and
- Codependency treatment.

Dental Services

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

Dental implants are not Covered.

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

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

Diabetes Services

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

Coverage for Diabetes Education must be:

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

Diabetes supplies and services:

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

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

Durable Medical Equipment

Upgraded or deluxe Durable Medical Equipment is not Covered.

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

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

Repair and Replacement

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

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

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

Orthotic Appliances

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

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

Prosthetic Devices

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

Surgical Dressing

Common disposable medical supplies that can be purchased Over-the-counter such as, but not limited to, bandages, adhesive bandages, gauze (such as 4 by 4 inches), and elastic wrap bandages are not Covered, except when provided in a Hospital or Practitioner's/Provider's office or by a home health professional.

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

Elastic Support hose are not Covered.

Eyeglasses and Contact Lenses

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

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

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

Visual training is not Covered.

Eye movement therapy is not Covered.

Exercise Equipment, Personal Trainers

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

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

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

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

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

Extracorporeal Shock Wave Therapy

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

Foot Care

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

Genetic Testing

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

Genetic Inborn Errors of Metabolism Coverage

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

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

Hair loss (or baldness)

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

Home Health Care Services/Home Intravenous Services and Supplies

Private duty nursing is not Covered.

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

Hospital Services

Acute medical detoxification in a residential treatment center is not covered. Rehabilitation is not Covered as part of Acute Medical Detoxification.

Infertility

Infertility services listed below are not Covered.

- Prescription Drug and Injections when provided by Practitioner/Provider.
- Reversal of voluntary sterilization is not Covered.
- Donor sperm is not Covered.
- In-vitro Gamete Intra Fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) fertilization are not Covered.
- Storage or banking of sperm, ova (human eggs), embryos, Zygotes or other human tissue is not Covered.
- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are not Covered.

Mental Health and Alcohol and Substance Use Disorder

Mental Health

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

Alcoholism Services and Substance Use Disorder Services

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

Nutritional Support and Supplements

- Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system for oral or tube feedings is not Covered.
- This plan does not cover a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of their practice.
- Nutritional supplements prescribed by an attending Practitioner/Provider not due to a deficiency or as the sole source of nutrition.

Outpatient Medical Services

- This plan does not cover a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of their practice.
- Email by a Practitioner/Provider for which the Practitioner/Provider charges.
- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided are not Covered.

Palliative Care

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

Practitioner/Provider Services

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

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

Office Visits listed below are not Covered:

- This plan does not cover a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of their practice.
- Email by a Practitioner/Provider for which the Practitioner/Provider charges.
- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided are not Covered.

Prescription Drugs/Medications

- Prescription Drugs/Medications that require a **Prior Authorization** when **Prior Authorization** was not obtained may not be Covered.
- New Prescription Drugs/Medications for which the determination of criteria for Coverage has not yet been established by our Pharmacy and Therapeutics Committee are not Covered.
- Prescription Drugs/Medications purchased outside the United States are not Covered.
- Non-Participating Provider meaning a Physician, Health Professional, Urgent Care Facility or Pharmacy who has not contracted with the Issuer to provide benefits to Members of the Plan are not Covered
- Prescription Drugs/Medications, medicines, treatments, procedures, or devices that we determine are Experimental or Investigational are not Covered.
- Prescription Drugs/Medications that have not been approved by the FDA are not Covered.
- Prescription Drugs/Medications prescribed for off-label or unproven indications when a Medical Necessity has not been established are not Covered.
- Prescription Drugs/Medications that are identified by Drug Efficacy Study Implementation (DESI) as Less than Effective (LTE) DESI drugs are not Covered.
- Replacement Prescription Drugs/Medications resulting from loss, theft, or destruction are not Covered.
- Disposable medical supplies, except when provided in a Hospital or a Practitioner's/Provider's office or by a home health professional, are not Covered.
- Prescription Drugs/Medications used in conjunction with In-vitro fertilization and artificial insemination are not Covered.
- Oral or injectable medications used to promote pregnancy are not Covered.
- Over-the-counter (OTC) medications and drugs are not Covered. Refer to our *Formulary* for a list of Covered OTC medications as determined by our Pharmacy and Therapeutics Committee.

- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are not Covered.
- Prescription Drugs/Medications for the purpose of weight reduction or control, except for Medically Necessary treatment for morbid obesity, are not Covered.
- Prescription Drugs/Medications used for cosmetic purposes are not Covered.
- Nutritional supplements as prescribed by the attending Practitioner/Provider or as sole source of nutrition are not Covered.
    - Infant formula is not Covered under any circumstance.
- Compounded Prescription Drugs/Medications are not Covered.
    - Bulk powders are not Covered.
    - Compounding kits are not Covered.
- Discount Cards or prescription Drug Savings Cards do not apply to Deductible or Out-of-pocket Maximum.
- Brand name drugs dispensed when a generic equivalent is available will not count towards Deductible or Out-of-pocket Maximums, unless Medical Necessity has been met.
- Herbal or alternative medicine and holistic supplements are not Covered.
- Vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, or functional capacity examinations related to employment are not Covered.
- Immunizations for the purpose of foreign travel, flight and or passports are not Covered.
- Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy including "all-natural" pills, creams, lotions and gels, and non-FDA-approved hormone pellets are Not Covered.
- Local Delivery of Antimicrobial Agents (LDAA) used for Periodontal Procedures are Not Covered.

Radiation

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

Reconstructive Surgery for Cosmetic Purposes

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

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

Rehabilitation and Therapy

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

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

- Athletic trainers or treatments delivered by Athletic trainers are not Covered.
- Vocational Rehabilitation Services are not Covered.
- Long-term Therapy or Rehabilitation Services are not Covered. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered Long-term Rehabilitation when:
    - You have reached maximum rehabilitation potential.
    - You have reached a point where Significant Improvement is unlikely to occur.
    - You have had therapy for four consecutive months.
    - Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, Cerebral Palsy, and Developmental Delays not associated with a defined event of illness or injury.
- Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, and Cerebral Palsy.
    - Note: This exclusion does not apply to benefits for medication or medication management or to certain services required to be covered under New Mexico state law for children with Autism Spectrum Disorders.

Speech Therapy services listed below are not Covered:

- Therapy for stuttering is not Covered.
- Voice Training is not Covered.
- Additional benefits beyond those listed in the **Speech Therapy Benefit Section** are not Covered.

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

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

Services Requiring Prior Authorization When Out-of-network

If you fail to obtain **Prior Authorization** for services received Out-of-network that require **Prior Authorization**, those services are not Covered. However, Members are not liable when an In-

network Practitioner/Provider does not obtain **Prior Authorization**. Refer to **Prior Authorization Section** for specific information.

Sexual Dysfunction Treatment

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

Skilled Nursing Facility Care

Custodial or Domiciliary care is not Covered.

Tobacco Cessation Services

Tobacco Cessation services listed below are not Covered:

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

Thermography

Thermography Services are not Covered.

Transplant Services

Transplant Services listed below are not Covered:

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

Treatment While Incarcerated

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

War

Any claim directly or indirectly occasioned by, happening through, or in consequence of war, acts of foreign enemies, hostilities (whether war be declared), acts of terrorism, civil war,

rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition or destruction of or damage to property by or under the order of government or public or local authority is not Covered.

Women's Health Care

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

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

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

Work-related Illnesses or Injuries

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

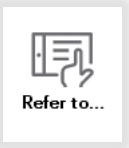
- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation Insurance.
- You fail to comply with any other provisions of the law.

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

Claims

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

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



Notice of Claim

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

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

Claim Forms

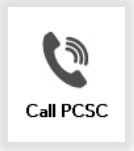
Presbyterian Health Plan, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within **15 days** after the giving of such notice the Member shall be deemed to have complied with the requirements of this policy as to the proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. Adequate proof of loss must be in the possession of the insurance company at the time funds are disbursed in payment of claims. You may access our website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000005494** to obtain a claim form. If such forms are not furnished within **15 days** after the giving of such notice the claimant shall be deemed to have compiled with the requirements of this policy.

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within **90 days** after the termination of the period for which the insurer is liable and in case of claim for any other loss within **90 days** after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give

proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

In-network Practitioners/Providers

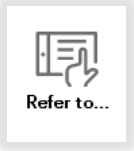
We reimburse In-network Practitioners/Providers for Covered services provided to you. You should not be required to pay sums to any In-network Practitioner/Provider, except for the required Cost-Sharing amount. You will be responsible for the payment of fees charged for missed appointments or appointments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



If you are asked by an In-network Practitioner/Provider to make any payments in addition to the Cost-Sharing amount specified in this Agreement, you should consult our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711** before making any such additional payments. You will not be liable to an In-network Practitioner/Provider for any sums that we owe the Practitioner/Provider.

Out-of-network Practitioners/Providers

Except for Emergency Health Care Services described in the **Accidental Injury (Trauma) / Urgent Care / Emergency Health Services / Observation Benefit Section**, you must receive our written **Prior Authorization** prior to receiving services from an Out-of-network Practitioner/Provider. Otherwise, you may be responsible for all charges incurred.



If you are Authorized to obtain services from an approved Out-of-network Practitioner/Provider, as specified in the **Prior Authorization Section**, you may be required to make full payment to that Out-of-network Practitioner/Provider at the time services are rendered. You should then submit the claim or a summary of the medical services rendered, in addition to Proof of Payment. Proof of payment includes a copy of the endorsed check, credit card statement or receipt showing that the services were paid in full satisfactory evidence to us that such payment was made to an Out-of-network Practitioner/Provider. Upon review and approval of the evidence of payment and **Prior Authorization**, we shall reimburse you for Covered Benefits, based upon Medicare Allowable Charges, less any required Copayment and/or Coinsurance you would have been required to pay if the services had been obtained from an In-network Practitioner/Provider. **You will be responsible for charges not specifically Covered by us.**

Emergency Health Care Services rendered to a Member while traveling outside of New Mexico shall be Covered as specified in the **Accidental Injury (Trauma) / Urgent Care/Emergency Health Services/Observation/ Benefits Section** of this Agreement.

Procedure for Reimbursement

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

If you need a claim form or have questions regarding a charge made by your Practitioner/Provider, please contact our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Claim forms are also available on our website at **www.phs.org**.

Please submit your completed claim form to:

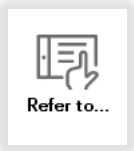
Presbyterian Health Plan
Attn.: Claims
P.O. Box 27489
Albuquerque, NM 87125-7489

Services Received Outside the United States

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

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

Claim Fraud



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

Effects of Other Coverage

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

Coordination of Benefits

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

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

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

- Subscriber/Dependent Rule
    - The plan, which covers you as the Subscriber, pays first.
    - The plan, which covers you as a Dependent, pays second.
- Birthday Rule for Dependent children of parents who are not separated or divorced.
- 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 parent not having physical custody of the child pays second.
        - The plan of the Spouse of the parent with physical custody (i.e., the stepparent) pays third.
- If you are covered under a motor vehicle or homeowner's insurance Agreement which provides benefits for medical expenses resulting from a motor vehicle accident or accident in your own home, you shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are covered by the motor vehicle or homeowner's insurance Agreement. If we have provided such benefits, we shall have the right to recover any benefits we have provided from you or from the motor vehicle or

homeowner's insurance to the extent they are available under the motor vehicle or homeowner's insurance Agreement.

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

In no event shall the Covered 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,

- We may release, request, or obtain claim information from any individual or organization. In addition, any Member claiming benefits from us shall furnish us with any information which we may require.
- We have the right, if we make overpayments because of your failure to report other coverage or any other reason, to recover such excess payment from any individual to whom, or for whom, such payments were made.
- We will not be obligated to pay for non-Covered Services or Covered Benefits not obtained in compliance with our policies and procedures.
- To the extent necessary for PHP to meet its obligations as a secondary carrier under NM regulations, PHP shall make payments for services that are received from non-participating providers, provided outside the service area, or that are not Covered under the terms of the contract or evidence of coverage.

Medicare

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

Medicaid

The Covered Benefits payable by us under this Agreement, on behalf of a Member who is qualified for Medicaid, will be paid to the state Health Care Authority, or its designee, when:

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

Subrogation (Recovering Health Care Expenses from Others)

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

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

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

Settlement of a legal claim or controversy without prior notice to us is a violation of this Agreement. In the event you fail to cooperate with us or take any other action, through agents or otherwise, which interferes with the exercise of our subrogation right, we may have, and hereby expressly reserve, all legal remedies available to us. Arbitration and mediation are not legal remedies available to Presbyterian. We do not require a covered person to submit a dispute to mediation or arbitration.

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

Summary of Health Insurance Grievance Procedures

This Section explains how to file a Complaint, Grievance and Appeal.

This is a summary of the process you must follow when you request a review of a decision made by your insurer. You will be provided with detailed information and appropriate complaint forms by your insurer at each step. In addition, you can review the complete New Mexico regulations that control the process under the **Managed Health Care Bureau** page found on the Office of Superintendent of Insurance (OSI) website, located at **www.osi.state.nm.us**. You may also request a copy from your insurer at **www.phs.org** or from OSI by calling **(505) 827-4601** or **1-855-427-5674**.

Prior Authorization

How does preauthorization or Prior Authorization for a healthcare service work?

When your insurer receives a request to pre-authorize payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process. Coverage: First, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for equine therapy, then your insurer will not agree to pay for you or your child to have it even if you have a clear need for it.

Medical necessity

Next, if the insurer finds that the requested service is covered by the policy, the insurer determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that your insurer pay for cosmetic plastic surgery to give you a more attractive nose, your insurer may approve your first request for hand surgery but disapprove the second request due to lack of medical necessity.

Experimental or Investigational Services

Depending on terms of your policy, your insurer might also deny authorization if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, the insurer may deny authorization. Your insurer might also deny authorization if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

Important: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. However, you will be responsible for paying the provider yourself for the services.

How long does Prior Authorization review take?

Standard timeline **Prior Authorization** decision: The insurer must make a **Prior Authorization** decision for most benefits within **seven working days.** A standard decision timeline applies to benefit certification requests that are not urgent. For example, a standard benefit certification request may involve surgical care, like routine hip replacement surgery. An insurer must make an initial decision on a standard request for an exception to an insurer's step-therapy requirements or drug *Formulary* within **24 hours** for urgent care requests and **72 hours** for standard care request. A step-therapy requirement means trying a less expensive drug before "stepping up" to a more expensive option. Asking for an exception to this requirement means asking to skip the less expensive drug. A drug *Formulary* exception request means to ask for coverage of a medication not on the *Formulary*.

What if I need services in a hurry?

Urgent care situation: An urgent care situation occurs when a decision from the insurer is needed quickly because:

1) Delay would jeopardize your life or health;
2) Delay would jeopardize your ability to regain maximum function;
3) The physician with knowledge of your medical condition reasonably requests an expedited decision;
4) The physician with knowledge of your medical or behavioral health condition, believes that delay would subject you to severe pain or harm that cannot be adequately managed without the requested care or treatment; or
5) The medical or behavioral health demands of your case require an expedited decision.

If you are facing an urgent care situation or your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer must either authorize or deny the initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case but within **24 hours** after receiving the request for an expedited decision.

Important: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the claims process once the emergency has passed.

When will I be notified that my initial request has been either certified or denied?

The insurance company is required to notify you of its decision about your initial request within the initial certification period timelines listed above. If the insurance company denies your certification request, it is required to tell you about your right to an appeal.

Appeals of Denials

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

Adverse Determination:

An adverse determination by an insurer includes any decision to deny or limit your coverage based on medical necessity. This medical necessity denial can happen preservice, through a denial of a **Prior Authorization**, or post-service, when an insurance company refuses to pay a claim. If an insurance company has adversely determined that your ongoing course of treatment that has been previously covered will no longer be covered, the insurer must notify you before ending or limiting that coverage. This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate.

An adverse denial may also include a decision by the plan to retroactively end your coverage or stop offering you coverage in the future based on your eligibility for coverage. For example, an insurance company's decision to stop offering you coverage because they believe you moved out of state is an adverse determination. You may request an appeal of any type of an adverse determination.

Administrative decision:

You may also request an appeal if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of Health Care Services; claims payment, handling, or reimbursement for Health Care Services; or if your coverage has been terminated.

How to Appeal a Decision or File a Grievance

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your policy. The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows:

Address: Presbyterian Health Plan
Attn.: Appeals and Grievance Department
P.O. Box 27489
Albuquerque, NM 87125-7489
Phone: **(505) 923-7528** or **1-855-923-7528**
Fax: **(505) 923-6111**
Email: **info@phs.org**

Always contact your insurance company first about filing an appeal or grievance and specifically ask for assistance filing an appeal or grievance.

If the insurance company is non-responsive or if you have further questions about your rights, you may contact the New Mexico Office of the Superintendent of Insurance Managed Health Care Bureau consumer assistance team at:

Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689
Santa Fe, NM 87504-1689
or
1120 Paseo de Peralta
Santa Fe, NM 87501
Phone: **(505) 827-4601** or **1-855-427-5674**
Fax: **(505) 827-4253**, Attn.: MHCB
Email: **mhcb.grievance@osi.nm.us**

Review of an Adverse Determination

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual policy holder or a dependent who receives

coverage through the policy holder. The person whose medical benefit is denied is called the "grievant." If you are selecting someone to act on your behalf, such as a provider, you may need to fill out a form designating that person to be your representative in the appeal.

Appealing an adverse medical necessity or coverage determination – first level review
If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may decide based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify the insurer that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that the insurer review its decision, you can ask the insurer to provide you with a list of the documents you need to provide and will provide you all your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review: If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than **72 hours** from the time the internal review request was received.

Standard review: Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within **30 days** after receipt of your preservice request for review or within **60 days** if you have already received the service.

The medical director denied my request – now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

> If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, including your attorney, appear with you or on your behalf. You may submit information that you want the panel to consider and ask questions of the panel members. Your health provider may also address the panel or send a written statement.

Important: If you are covered under the NM State Healthcare Purchasing Act as a public employee, you may not request an IRO review if you skip the panel review.

If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

How long do I have to make my decision?

If you wish to have your request reviewed by the insurer's panel, you must inform the insurer within **five days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter, go directly to the IRO, you must inform OSI of your decision within **four months** after you receive the medical director's decision.

What happens during a panel review?

If you request that the insurer provide a panel to review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone or arrange to have someone attend with you or on your behalf. You may review all the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement. The insurer's internal panel must complete its review within **30 days** following your original request for an internal review of a request for precertification or within **60 days** following your original request if you have already received the services. You will be notified within **24 hours** after the panel decision or sooner if medically necessary. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, but the review process may take much longer and you will be forced to wait for a decision.

Important: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of **30 days**.

If I choose to have my request reviewed by the insurer's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have four months from the date of the panel decision to request a review by an IRO.

What's an IRO and what does it do?

An IRO (Independent Review Organization) is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with the insurer or with you. The reviewer will consider all the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO.) In deciding, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the insurer must provide them.

The IRO's fees are billed directly to the insurer – there is no charge to you for this service.

How long does an IRO review take?

The IRO must complete the review and report back within **20 days** after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within **72 hours** after receiving all the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI within **20 days** of the IRO decision, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within **30 days** after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within **180 days** after the date you are notified of the decision. The insurer will notify you within **three days** after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

The insurer will mail a decision to you within **30 days** after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have **20 days** to request that the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within **15 days** after the insurer receives your request. You will be notified at least **five days** prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to **30 days**. The reconsideration committee will mail its decision to you within **seven days** after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at **www.osi.state.nm.us**. You may also call OSI to request the forms at **(505) 827-4601** or **1-855-427-5674**.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has **five days** to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all the information received from both you and the insurer and issue a final decision within **45 days** after receipt of the complete request for external review. If you need extra time to gather information, you may request an extension of up to **90 days**. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with your personal healthcare records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release. Should you pursue external review with OSI your medical records may be subject to the New Mexico Inspection of Public Records Act ("IPRA"). Under IPRA every person has the right to inspect public records of any New Mexico government agency including OSI, subject to certain exemptions.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations. Call the consumer assistance number on the back of your insurance card for assistance.

The preceding summary has been provided by the Office of the Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

Records

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

Creation of Non-Medical Records

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

Accuracy of Information

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

Consent for Use and Disclosure of Medical Records

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

Professional Review

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

Confidentiality of Protected Health Information/Medical Records

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

What is PHI?

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

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

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

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

Access to PHI

All confidential documents are kept in a physically secure location with access limited to authorized Plan personnel only. You (or your legal guardian/Personal Representative) have the right, with certain exceptions, to request access to inspect and obtain a copy of your PHI. Genetic information will not be disclosed unless permitted and will never be used for underwriting purposes. We may charge a reasonable fee for providing a copy, summary or explanation of the information you request. If there is a fee, we will tell you how much it will cost before we provide the requested information. You may change your request to avoid or reduce the fee.

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

- Psychotherapy notes
- Information gathered in reasonable expectation of, or for use in, a civil, criminal, or Administrative action or proceeding
- PHI maintained by us that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 U.S.C. 263a, to the extent the provision of access to you

would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988 (CLIA), pursuant to 42 CFR 493.3(a)(2).

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

Address: Health Information Management
Attn.: Medical Records Department
P.O. Box 26666
Albuquerque, NM 87125-6666

Phone: **(505) 841-1944**
Fax: **(505) 841-1153**
Email: **phsroi@phs.org**

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

Routine Uses and Disclosures of PHI

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

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

We do not disclose PHI to anyone other than as permitted by the plan documents or required by law. We use and disclose information we collect only as necessary to deliver healthcare products and services to you in accordance with our Contracts, or to comply with legal requirements. Our employees refer to your Personal Health Information only when necessary to perform assigned duties for their job. Our employees handle your health records according to our stringent confidentiality policies.

Consents/Authorizations

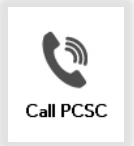
Although consent/authorization from you (or your legal guardian/Personal Representative) is not required to use or disclose PHI for certain purposes specified in the law, a Practitioner/Provider shall request that you (or your legal guardian/Personal Representative) sign an authorization form permitting disclosure of medical records (to the extent permitted by law) to us at the time of your first visit to the Practitioner/Provider.

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

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

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

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



To request an Authorization Form, please contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. An Authorization Form also may be obtained through MyChart. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**. Authorization Forms will be kept in your medical record and/or enrollment file.

Members Who Are Unable to Give Consent/Authorization

Sometimes courts or doctors decide that certain people are unable to understand enough to make decisions for themselves. Usually, a person with legal authority to make healthcare decisions for a child or other person (for example, a parent or legal guardian) can exercise the health

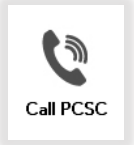
information rights described herein for the child or other person, but not always. Unless otherwise required or permitted by law, when we need an Authorization Form signed for a person who can't make healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

Right to Request Amendments (Changes) to PHI

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

Process for Members to Request an Accounting of Disclosures of PHI

You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center by calling Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you.



Restriction of PHI Use or Disclosures

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

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

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

Use of Measurement Data

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

Internal Protection of Oral, Written and Electronic PHI Across PHP

To ensure internal protection of oral, written, and electronic PHI across our organization, the following rules apply:

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

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

Website Internet Information

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

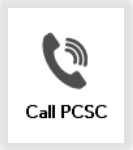
- Website traffic statistics, including:
    - Where visitor traffic comes from
    - How traffic flows within the website
    - Browser type

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

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

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

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



If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**.

Eligibility, Enrollment, Effective Dates, Termination and Continuation

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

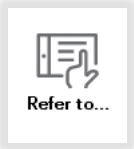
How You Can Enroll as a Member

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

Eligible Subscribers

A Subscriber is the person to whom the Contract is issued. To be eligible to enroll as a Subscriber, you must:

- Physically live in the State of New Mexico, our Service Area.
- Coverage for undocumented immigrants is accepted from every eligible employer or individual that applies for coverage.
- You and/or your Dependents cannot be eligible for Medicare.
    - Members have the choice of whether to enroll in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease (ESRD).



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

Eligible Dependents

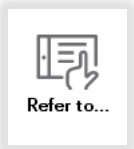
A Dependent is a family member of a Subscriber as described in this Section. To be eligible to enroll as a Dependent for Coverage and become a Member, your Dependent must be:

- Your legally married Spouse (of the Subscriber), as defined by state law.
    - Physically live in the State of New Mexico, our Service Area.
    - Must not be Medicare Eligible.
        - Members have the choice of whether to enroll in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease (ESRD).
- Your Dependent child who is:

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

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

The enrollment of a Dependent child after they turn **age 26**, for Covered benefits under this contract, will be reapply for new coverage due to an involuntary loss of coverage.



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

Court Ordered Coverage for Dependent Children in the Service Area

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

Dependents of Non-Custodial Parents

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

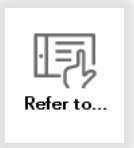
- Provide such information to the custodial parent as may be necessary for the child to obtain Covered Benefits.
- Permit the custodial parent or the Practitioner/Provider, with the custodial parent's approval, to submit claims for Covered Benefits without the approval of the non-custodial parent.
-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

Residence of a Dependent Child

Dependent Student

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

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



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

Total and Permanent Disability of an Enrolled Dependent Child

At the end of the plan year when an enrolled Dependent child reaches their **26th birthday** and is totally and permanently disabled, the Coverage of the Dependent under this Agreement will not terminate. The enrolled Dependent must be incapable of self-sustaining employment by reason of intellectual disability or physical disability and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, the member's provider would submit the documentation to Presbyterian with proof of such disability, incapacity and dependence within **31 days** of the Dependent child's attainment of **age 26**. Presbyterian routinely sends a letter to members notifying them of their pending termination as they age out of their parent/guardians plan. The letter informs them that their provider must submit documentation providing evidence of the members disability to remain on their parent/guardians plan. Once evidence of the disability is provided, it is reviewed by the Medical team and if approved, the member is allowed to stay on their plan. If we approve continued Coverage, we may request proof of the disability on each birthday thereafter.

Medicare-Eligible Members (TEFRA)
Subscribers and Dependents Who May Not Enroll

- A Subscriber's grandchild is not eligible for Coverage unless the grandchild meets the eligibility criteria for a Dependent.
- A child born of a Member, when the Member is acting as a surrogate parent, is not eligible for Coverage.

- A Subscriber and/or Dependent is not eligible to enroll for Coverage if either Subscriber or Dependent has had a prior Contract or Agreement with us terminated for Good Cause as described in the **Glossary of Terms Section** or under any similar Sections of our other Agreements, unless we review and approve the new enrollment, in writing.

Enrollment and Effective Dates

If you meet the Subscriber or Dependent eligibility criteria, you may enroll in our Coverage by submitting the completed Application forms to:

Address: BeWellnm
7601 Jefferson Rd NE, Ste 120
Albuquerque, NM 87109

Phone: **1-833 862-3935 (TTY 711)**
Online: **www.bewellnm.com**

- Annual open enrollment is from November 1 to December 15.
- Subscribers and eligible Dependents may begin receiving services for Covered Benefits at 12:01 a.m. on the approved effective date after all of the requirements below have been met.
- The names of the Subscribers and eligible Dependents have been received in writing by us.
- All submission deadlines have been met.

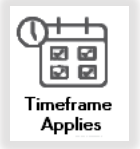
Qualifying Events for Coverage and Special Enrollment Periods (SEPs)

When you are currently enrolled as a Subscriber, you may make certain changes to your Coverage due to a qualifying life event. We will require evidence of a qualifying life event in order to change your coverage through a Special Enrollment Period. You must complete and sign a Qualifying Event Form and submit it within **60 days** of the date of the change in family status. Terminating Coverage for a Dependent from your benefit plan Coverage is not an event that allows you to change your benefit Plan.

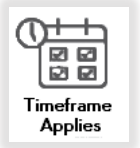
We recognize the following Qualifying Events as a reason for adding or removing Dependents:

- Loss of other Health Insurance Coverage or loss of other health insurance due to divorce.
- Gaining U.S. citizenship
- Moving your residence to a new rating area
- Marriage
    - Your newly acquired Spouse (and any children of the Spouse eligible for Coverage under this Section) is eligible to be enrolled as a Dependent. Your

spouse (and any child of the spouse eligible for Coverage) must complete and sign a Qualifying Event Form and submit it within **60 days** from the date of marriage. Coverage will be effective as of the first day of the month following the date we receive the notification of divorce or legal separation.
    - You must notify us within **60 days** of the date of divorce or legal separation of the change in Dependent Coverage. Termination will be effective as of the last day of the month following the date we receive the notification.
- Birth of a child
    - Your newborn or the newborn of your Spouse will be Covered from the moment of birth if we receive the signed and completed Qualifying Event Form within **60 days** from the date of birth.
    - If the Qualifying Event Form is not received within **60 days** of the birth, then the newborn is not eligible for family coverage.



- Adoption of a child
    - A child under **age 18** who is placed in your home for the purposes of adoption and for whom you have commenced adoption proceedings is eligible to be enrolled as a Dependent.
    - The child will be Covered from the date of placement for the purpose of adoption when we receive the signed and completed Qualifying Event Form within **60 days** the date of placement.
    - The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child.
    - Such child shall continue to be eligible for Coverage unless placement is disrupted prior to legal adoption. The legal obligation terminates when placement terminates or is disrupted.



- Legal Guardianship
    - If you or your Spouse becomes the legal guardian for any child pursuant to court order, the child is eligible to be enrolled as a Dependent. You must submit a completed, signed Qualifying Event Form within **60 days** of the date of the court and/or qualified administrative order granting guardianship.
    - The Dependent child will become a Member on the first day of the month following the date the order is filed with the clerk of the court. The Dependent child will continue to be eligible until such time as you or your Spouse are no longer the legal guardian for such child.

- Court ordered or qualified administrative ordered eligible Dependent Coverage
    - If you are required by a court or administrative order to provide Coverage for an eligible Dependent child, the Dependent child may be enrolled.
    - You must submit a completed and signed Application within **60 days** from the date on which the Subscriber receives the court order or qualified administrative order.

- The Coverage for the eligible Dependent child will become effective on the date in accordance with the court or administrative order. If the court order does not stipulate an effective date, the Dependent child will become Covered effective the first day of the month following the date the order was filed as public record with the court. In a case where the Subscriber was not previously compliant to the order, the effective date for the Dependent child will be the first day of the month following the receipt of the request.
- A grandchild is not eligible for Coverage under this plan unless the Subscriber has adopted the grandchild or is the legal guardian or has been ordered by a court of law or qualified administrative order to provide healthcare Coverage for the grandchild as identified above. This includes but is not limited to children of non-custodial children.

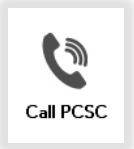
Full, Accurate and Complete Information

You, as a Subscriber, must fully and accurately complete and sign an Application for Coverage as required. False or fraudulent statements or intentional misrepresentations of material fact provided in an Application may result in the Termination of all Coverage for you and your Dependents.

A retroactive Termination of Coverage or rescissions (back to the initial date of enrollment) for fraud or intentional misrepresentation of material fact, except for those attributable to failure to pay prepayments, premiums or contributions may occur. This rule does not apply to prospective Termination of Coverage.

We will provide at least **30 days** advance written notice to each participant who would be affected prior to rescinding coverage.

Change in Address, Family Status



Changes in your Dependents, marital status, or address may affect your Coverage under this Agreement. You may notify us directly by calling our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Or visit our website at **www.phs.org**. A member's premium may only be adjusted once per **12-month** (annual) term.

Termination of Coverage

This Agreement shall be canceled and shall terminate in the event any one of the following conditions occurs:

- **Nonpayment**
  - If premium payment has not been received by Presbyterian Health Plan on or before the first day of the coverage month, a grace period is triggered. The grace

period is different for enrollees who receive an Advance Premium Tax Credit (APTC).
    - With APTC, the grace period is **90 days**.
    - Without APTC, the grace period is **31 days**.
    - Partial payments will not adjust a grace period. If a subscriber is eligible for an APTC but elects not to receive the credit in advance, they do not qualify for the **90-day** grace period. The **90-day** grace period only applies to enrollees who are receiving an APTC.
    - Cancelation and termination of this Agreement under this paragraph shall become effective as of the last date of Prepayment. We shall be entitled to recover from the Subscriber any and all payments for Covered Benefits made on behalf of any Subscriber or the Subscriber's Dependent(s) after the last date of the period for which Prepayment was received.
- **Voluntary Termination**
  Coverage may be terminated by the Subscriber by one of the following termination deadlines:
    - A Voluntary Termination request may be made by the subscriber either in writing, verbally, or by email. Voluntary Termination requests may be submitted to PHP by the last day of the month in order to terminate the Coverage at the end of that current month.
    - If the Voluntary Termination request is received after the last day of the month, the policy will terminate at the end of the following month.
    - If a member voluntarily terminates, there would not be a Special Enrollment Period (SEP) to reapply for Coverage until the next open enrollment period.
- **Ten-day** review of Contract
    - You are allowed a **10-day** period, from the effective date of the Contract, to examine and return the Contract and have the premium refunded. If services were received during the **10-day** period, and you return the Contract to receive a refund of the premium you paid, you must pay for such services. Submissions of this type would be processed through BeWellNM.
- **Automatic Termination**
    - This Agreement Shall be canceled and your (Subscriber and Dependent) Coverage shall terminate in the event any one of the following conditions occurs.
        - We will not terminate your Coverage for nonpayment of Cost-Sharing amounts during any period in which you are Hospitalized and receiving treatment for a life-threatening condition. In addition, we will not terminate your Coverage for refusal to follow any prescribed course of treatment.
            - A grace period of **31 days** will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.
            - Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not

be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

- Termination during hospitalization
    - We will not terminate your Coverage for nonpayment of Cost-Sharing amounts during any period in which you are Hospitalized and receiving treatment for a life-threatening condition. In addition, we will not terminate your Coverage for refusal to follow any prescribed course of treatment.
- **False Material Information/Rescissions**
    - On the date we specify, this Agreement will terminate if you (the Subscriber) have knowingly given false material information in connection with your eligibility or enrollment of you or any of your Dependents, provided we send written notice to you (the Subscriber) at least **30 days** in advance of such termination. In such case we, at our sole discretion, may terminate Coverage for you (the Subscriber) and all of you Dependents, and may make such termination effective retroactively as the date of enrollment. You shall be responsible for payment for all Health Care Services rendered hereunder as of the effective date of such termination and shall reimburse us for all such Health Care Benefit payments that we made on your behalf or on behalf of any of your Dependents.
- **Medicare Eligibility**
    - It is your responsibility to advise us when you become eligible for any part of Medicare (i.e., Part A or B). We will terminate the coverage once Presbyterian is notified. You shall be responsible for payment for all Health Care Services rendered hereunder as of the effective date of such termination and shall reimburse us for all such Health Care Benefit payments that we made on your behalf or on behalf of your Covered Dependent who is eligible for any part of Medicare (i.e., Part A or B) at the end of the month for which premiums have been paid.
- **Military Service:** Coverage for you (Subscriber) and your eligible Dependents will terminate at the end of the month during which you entered into active military duty (except for temporary duty of **30 days** or less).
- At the end of the Contract month in which you (the Subscriber) cease to physically live or work within the state of New Mexico, our Service Area. Coverage for all Dependents will terminate on the same date as your (the Subscriber's) coverage.
- At the end of the month in which you (the Subscriber) or your Dependents cease to be eligible.
- On the date that adoption placement for the child originally placed for adoption, is disrupted prior to legal adoption, and is removed from placement.
- As of the date on which you permit the use of your Identification card by any other person we may, at our discretion, terminate Coverage for you and for all Dependents. We must send written notice to you (the Subscriber) at least **30 days** in advance of such termination.
- We may terminate the Contract with you at the end of any month for Good Cause by giving written notice of termination **30 days** prior to the effective date of termination.

Upon termination of this Agreement, all payments and fees which are accrued and unpaid at the time of termination shall be due to us.

- A deceased subscriber or dependent will be terminated when notification is supplied to Presbyterian Health Plan.
- If you or any of your Dependents are terminated for Good Cause, as defined in the **Glossary of Terms** section, then you or any of your Dependents are not eligible for Individual Conversion.
- No statement (except a fraudulent statement) made by any Member in any Application for Coverage which is more than **2 years old** can void this Coverage or be used to deny a claim for loss incurred under this policy unless the Application or a true copy of it is incorporated in or attached to the Contract.

We will not terminate Coverage under this Agreement for any Member based solely upon the Member's health status, requirements for Health Care Service, race, gender, age, sexual orientation, or for refusal to follow a prescribed course of treatment. If you or your Covered Dependents believe that Coverage was terminated due to health status or healthcare requirements, you may Appeal the cancelation to the Superintendent of Insurance at:

Mailing Address: Office of Superintendent of Insurance
Attn.: External Review Request
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
Email: **mhcb.grievance@state.nm.us**
Fax: **(505) 827-4253**

Unless we agree, in writing, no Covered Benefits shall be provided under this Agreement following the date this Agreement terminates including, but not limited to, when you or your Covered Dependent remains in the Hospital after the date of termination of this Agreement.

We shall be entitled to recover from you (the Subscriber) any and all payments for Covered Benefits made on behalf of you or your Dependents after the last date this Agreement was in force.

Notice of Termination to Members

If this Agreement is terminated for cause, we will send a Notice of Cancelation to you (the Subscriber) no less than **30 days** prior to the effective date of termination.

- The notice will be dated
- State the reason(s) for termination

- State your right to file a Complaint with the Superintendent of Insurance if you feel you have been wrongly disenrolled (had your Coverage terminated)
- Provide information about your ability to enroll in a conversion plan
- Include other matters required by law, including information related to premium refunds, if any, and reinstatement

Continuation of Coverage of Your Plan

A Dependent(s) may transfer to a separate individual policy without further proof of insurability if a Dependent(s) loses eligibility due to any of these involuntary events:

- Divorce, annulment or dissolution of a marriage, or legal separation of the spouse from the Subscriber.
- At the end of the year of the **26th birthday** of a Dependent Child they will be offered to apply for separate coverage.
- The Subscriber's eligibility for Medicare.

Coverage will be continuous if a notice of change is received by us within **60 days** of the qualifying event, however, the plan must remain the same as the original plan issued. If the notice of change is not received within **60 days** of the qualifying event, this transfer of Coverage will not be available.

In the event of the death of the Subscriber, Coverage for enrolled Dependents will be continued without further proof insurability as long as Prepayments are continued. Please contact us for the appropriate paperwork required for this continuation of Coverage.

- Continuation of Coverage is not available when the terminating Member resides outside of the State of New Mexico.
- Continuation of Coverage is not available to any Dependent who is eligible for or enrolled in Medicare.

Discontinuance of Your Plan

In the event that PHP decides to discontinue offering this plan, PHP will provide a notice to you at least **90 days** prior to the date of discontinuing the coverage. You will be offered other available coverage PHP offers in the individual market. In the event that PHP decides to discontinue all coverage in the individual market, PHP will notify you of this at least **180 days** prior to the date of discontinuance.

Premium Payment

This Section explains how premium payments are to be made to Presbyterian Health Plan.

Prepayments

Prepayments, as identified in the approval letter or any notice of Prepayment change, are payable in advance of the next month by the Subscriber or the financially responsible party to us at our offices in Albuquerque, New Mexico. Prepayments may be drafted each month from the Subscriber's or financially responsible party's bank account or credit/debit card as specified on the Subscriber's application and outlined in the Subscriber's approval letter or the Subscriber may select monthly "bill me" option.

If the transaction is returned by the Subscriber's or financially responsible party's financial institution for insufficient funds, account closed, authorization revoked, or any other reason caused by an act of the Subscriber or financially responsible party, payment of the amount billed plus a finance charge must be received by us within **31 days** from the date the Prepayment was due. Failure to remit payment in full (including any applicable finance charge) within this timeframe will result in termination effective as of the last day of the month for which payment has been received. If the premium is returned or reimbursed, it is reimbursed at a pro-rata rate.

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

Changes in Prepayments

We reserve the right to change the Prepayment amount for the Covered Benefits provided under this Agreement as follows:

- At the beginning of any month in which we have given the Subscriber **60 days** prior written notice of change in Prepayment.
- At the beginning of the month in which you (the Subscriber) changes Coverage classifications such as:
    - New geographic location.
    - Addition of Dependent(s).
- On any date that the provisions of the Agreement are amended which result in a premium change. We shall give written notice of such change in Prepayment amount to you (the Subscriber) at least **60 days** prior to the effective date of the Prepayment change.

When Premiums Are Not Paid On Time and Grace Periods

A grace period or such other time period as required or permitted by applicable law, regulation or guidance of **31 days** will be granted for the payment of each premium falling due after the first premium, during which grace period, or such other time period as required or permitted by applicable law, regulation, or guidance, the Plan shall continue in force, however, Claim payments for Covered Services received during the grace period or such other time period as required or permitted by applicable law, regulation or guidance, may be pended until full premium payment is made, and during the grace period or such other time period as required or permitted by applicable law, regulation or guidance, your Providers and pharmacies may require you to pay for your healthcare and prescription drug expenses in full. After a grace period or other such time period as required or permitted by applicable law, regulation or guidance, of **31 days**, coverage under this Plan will automatically terminate on the last day of the coverage period for which premiums have been paid, unless coverage is extended as described in the next paragraph.

In the event you are receiving a Premium Tax Credit under the Affordable Care Act, you are eligible for a three-month grace period or such other time period as required or permitted by applicable law, regulation or guidance, for paying premiums due after the first premium. If full premium is not paid within one month of the premium due date, claim payments for Covered Services received during the second and third calendar months of the grace period or such other time period as required or permitted by applicable law, regulation or guidance, under this Plan will be pended until full premium payment is made. During the grace period or such other time period as required or permitted by applicable law, regulation or guidance, your Providers and pharmacies may require you to pay for your healthcare and prescription drug expenses in full. If full payment of the premium is not made within the three-months grace period, or such other time period as required or permitted by applicable law, regulation or guidance, then coverage under this Plan will automatically terminate on the last day of the first month of the three-month grace period or such other time period as required or permitted by applicable law, regulation or guidance. PHP will not process any claims for services after the date of termination and any pended claims will be denied. If coverage is terminated for nonpayment of premium, any claims received and paid for during the **31-day** Grace Period or such other time period as required or permitted by applicable law, regulation or guidance, will be billed to you.

When you renew PHP coverage or re-enroll by selecting a new product, you will need to be current on your premium payments. Any past due premium payments for coverage we provided will be due at the beginning of the new Plan Year in addition to current premium charges. New coverage will not be effective until all such payments are made.

General Provisions

This Section explains important information and provisions not covered in other sections of this Agreement.

Amendments

This Subscriber Agreement (Agreement) shall be subject to amendment, modification, or termination in accordance with their provisions or by mutual agreement in writing between us and the Subscriber. By electing Coverage or accepting benefits under this Agreement, you (the Subscriber) and all Members legally capable of contracting, agree to all the terms, conditions, and provisions of this Agreement.

Assignment

All your rights to receive benefits and services are personal and may not be assigned.

Availability of Provider Services

Presbyterian Health Plan does not guarantee that a Hospital, facility, Physician, or other Practitioner/Provider will be available in the PHP network.

Conformity with state statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Entire Contract

This Agreement, the Summary of Benefits and Coverage, any applications, amendments, Endorsements, supplements or riders, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive office of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Execution of Contract – Application for Coverage

The parties acknowledge and agree that your signature or execution of the Application shall be deemed to be your acceptance of the Contract, including this Agreement. All statements, in the absence of fraud, made by any applicant (you and/or your Dependents) shall be deemed representations and not warranties. No such statements shall void Coverage or reduce benefits unless contained in a written Uniform Medical Assessment Form, which is an Application for Coverage.

Federal and State Health Care Reform

We shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects our obligations under this Agreement, this Agreement will be deemed automatically amended such that we shall remain in compliance with the obligations imposed by such law, rule or regulation.

Fraud

We are required to cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Practitioner/Provider activity and Member activity.

Practitioner/Provider Activity

If you suspect that a Practitioner, pharmacy, Hospital, facility or other Health Care Professional has done any of the items listed below, please call the Practitioner or Provider and ask for an explanation. There may be an error.

- Charged for services that you did not receive
- Billed more than one time for the same service
- Billed for one type of service, but gave you another service (such as charging for one type of equipment but delivering another less expensive type)
- Misrepresented information (such as changing your diagnosis or changing the dates that you were seen in the office)

If you are unable to resolve the issue, or if you suspect any other suspicious activity, please contact our Special Investigative Unit (SIU) hotline at **(505) 923-5959** or **1-800-239-3147**. This confidential voicemail box is available **24 hours** a day. Any information you provide will be treated with strict confidentiality. When reporting suspected health insurance fraud, you may remain anonymous. You can also contact the SIU at:

Address: Presbyterian Health Plan
Special Investigative Unit (SIU)
P.O. Box 27489
Albuquerque, NM 87125-7489

Email: **PHPFraud@phs.org**

Online: **https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/form**

Member Activity

Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate enrollment for any Member for any type of fraudulent activity. Some examples of fraudulent activity are:

- Falsifying enrollment information
- Allowing someone else to use your ID Card
- Forging or selling prescriptions
- Misrepresenting a medical condition in order to receive Covered Benefits to which you would not normally be entitled

Governing Law

This Agreement is made and shall be interpreted under the laws of the state of New Mexico and applicable federal rules and regulations.

Identification Cards

We issue Identification (ID) Cards to you, pursuant to the Agreement, for identification purposes only. Possession of our ID Card confers no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the ID Card must, in fact, be a Member on whose behalf all applicable Contract charges have actually been paid. If you or any family Member permits the use of your ID Card by any other person, all your rights and other Members of your family pursuant to this Agreement may be immediately terminated at our discretion. Any person receiving services or other benefits to which they are not then entitled pursuant to the provisions of this Contract shall be charged therefore at the rates generally charged in the area for medical, Hospital and other Health Care Services.

Legal Actions

No action at law or in equity shall be brought to recover on this Agreement by the Member prior to the expiration of **60 days** after written proof of loss has been furnished, in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of **three years** after the time written proof of loss is required to be furnished.

Misrepresentation of Information

If, in the first **two years** from the effective date of your and/or your Dependents Coverage, we determine that you intentionally omitted information from the Universal/Uniform Medical Assessment form or other Coverage Application and/or you provided fraudulent or false information, the Coverage for you and/or your Dependent shall be null and void from the effective date. In the case of fraud, no time limits shall apply, and you will be required to pay for all benefits that we have provided.

Misstatements

No misstatements, except fraudulent misstatements, made by the applicant in the Universal/Uniform Medical Assessment Form or other Application for Coverage for this Contract shall be used to void the Contract or to deny a claim for loss incurred or disability (as defined in this Subscriber Agreement). If you or your dependents age has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

Notice

If we are required or permitted by this Agreement to give any Notice to the Subscriber or Member, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to the Subscriber or Member at the address of record on file at our principal office. The Subscriber and/or Member is solely responsible for ensuring the accuracy of their address of record on file with us.

Personal Convenience Items

This plan does not include personal convenience items, including, but not limited to, an appliance device, object or service that is for comfort and ease and is not primarily medical in nature, such as, shower or tub stools/chairs, seats, bath grab bars, shower heads, hot tubs/Jacuzzis, vaporizers, accessories such as baskets, trays, seat or shades for wheelchairs, walkers and strollers, clothing, pillows, fans, humidifiers, and special beds and chairs (excluding those covered under the durable medical equipment benefit).

Policies and Procedures

We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

Reinstatements

We may reinstate this Agreement after termination **without** the execution of a new Application or the issuance of a new Identification Card or any notice to the Subscriber or Member, other than the unqualified acceptance of an additional payment from the Remitting Agent.

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurance company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurance company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its

disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than **10 days** after such date. In all other respects the insured and insurance company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than **60 days** prior to the date of reinstatement.

Right to Examine

We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Time Limits

You have the right to continue in force subject to its terms by the timely payment of premium until at least **age 50** or in the case of a policy issued after **age 44**, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause in parentheses may be omitted at the insurance company's option, under the caption "Incontestable."

Waiver by Agents

No agent or other person, except an officer of Presbyterian Health Plan has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making payment, or to bind Presbyterian Health Plan by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an Endorsement or amendment in writing to this Agreement.

Workers' Compensation Insurance

This Agreement is not in lieu of and does not affect any requirement for Coverage by the New Mexico Workers' Compensation Act. However, an employee of a professional or business corporation may affirmatively elect not to accept the provisions of the New Mexico Workers' Compensation Act. More specifically, an employee may waive workers' compensation Coverage provided that the following criteria have been met:

- The "employee" is an executive officer of a professional or business corporation; and
- The "employee" owns **10%** or more of the outstanding stock of the professional or business corporation.

For purposes of the New Mexico Workers' Compensation Act, an "executive officer" means the chairperson of the board, president, vice-president, secretary or treasurer of a professional or business corporation.

In the event that an employee chooses to opt out of workers' compensation Coverage, and meets the criteria as stated above, PHP will provide **24-hour** healthcare Coverage to those employees, subject to the eligibility requirements for Coverage with PHP. In addition to meeting all of PHP's eligibility requirements, documentation indicating that the aforementioned criteria have been met will be required in order for Coverage with PHP to become effective.

Glossary of Terms

This Section defines some of the important terms used in this Agreement. Terms defined in this Section will be capitalized throughout the Agreement.

Abortion (excepted and non-excepted) Excepted are services defined as such by the Affordable Care Act (ACA). Excepted means the pregnancy is the result of rape or incest, or the life of the pregnant woman would be endangered unless an abortion is performed. Non-excepted means abortion services that do not meet this criteria.

Accidental Injury means a bodily injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia or cerebral vascular accident. Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury.

Acupuncture means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

Acute Medical Detoxification is a form of drug and alcohol abuse treatment in which a patient is weaned off their alcohol or drug addiction immediately with the help of medical supervision. It is a serious medical process that usually takes **three to five days**, depending on the substance.

Administrative Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding any aspect of a Health Benefits Plan other than a request for Health Care Services, including but not limited to:

- Administrative practices of the Health Care Insurer that affect the availability, delivery, or quality of Health Care Services
- Claims payment, handling or reimbursement for Health Care Services
- Terminations of Coverage

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are

otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Adverse Determination Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding an Adverse Determination.

Agreement means this Subscriber Agreement, including supplements, Endorsements or riders, if any.

Alcoholism means alcohol dependence or alcohol use disorder meeting the criteria as stated in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013 for these disorders.

Alcohol Dependency Treatment Center: A specialized treatment facility for alcohol and/or drug use disorders. This refers to treatment centers, departments, wards and units designed and designated for treatment of Substance Use Disorders. These facilities can be stand-alone (like, for example, national addiction treatment centers, drug treatment centers/clinics, narcological dispensaries) or integrated with other healthcare centers, clinics or dispensaries (such as general healthcare or mental health centers or hospitals, HIV clinics, etc.).

Ambulance Service means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

Annual Out-of-pocket Maximum means a specified dollar amount of Covered Services received in a Contract Year that is the most the Member will pay (Cost-Sharing responsibility) for that Contract Year.

Appeal means a request from a Member, or their representative, or a Practitioner/Provider who is representing a Member, to Presbyterian Health Plan, for a reconsideration of an Adverse Determination (denial, reduction, suspension or termination of a benefit).

Application means the forms, including the required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for our Coverage.

Applied Behavior Analysis (ABA) is a psychological intervention that applies tailored approaches based upon the principles of respondent and operant conditioning to change behavior. ABA is designed to meet the unique needs of the individual to work on skills that will help them achieve short and long-term changes that better ensure their future success and independence.

Authorized means **Prior Authorization** was obtained (when required) prior to obtaining Health Care Services both In-network and Out-of-network.

Authorization means a decision by a Health Care Insurer that a Health Care Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Health Care Insurer's requirements for Coverage and Medical Necessity, and the requested Health Care Service is therefore approved. See **Certification**.

Autism Spectrum Disorder means a condition that meets the diagnostic criteria for the pervasive development disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, including Autistic Disorder; Asperger's Disorder; Pervasive Development Disorder not otherwise specified; Rett's Disorder; and Childhood Disintegrative Disorder.

Balance Billing is when a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is **$100** and the allowed amount is **$70**, the provider may bill you the remaining **$30**. A preferred provider may not balance bill you for Covered services. Balance billing could include an unexpected Out-of-network bill for services, which would be considered a surprise bill subject to the No Surprises Act.

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Bears the Legend means that a prescription drug label is required by federal law (specifically the Federal Food, Drug, and Cosmetic Act, as amended) to carry a specific statement or symbol indicating that it can only be dispensed with a valid prescription

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions and thereby alleviate an abnormal bodily condition.

Biosimilar Drug is a biological product that is highly similar to an existing FDA-approved product. It has no meaningful difference in terms of safety, purity, and potency.

Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or recurrence, early detection or treatment of cancer that is being provided in New Mexico.

Cardiac Rehabilitation means a program of therapy designed to improve the function of the heart.

Certification of Service means a determination by a Health Insurance carrier that a Health Care Service requested by a Health Care Professional or Covered Person has been reviewed and, based upon the information available, is a Covered Benefit and meets the carrier's requirements for Medical Necessity, appropriateness, healthcare setting, level of care and effectiveness, and

the requested Health Care Service is therefore approved. The Certification of Service can take place following the health carrier's utilization review process.

Certified Nurse Midwife means any Person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse-Midwife.

Certified Nurse Practitioner means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the board of nursing.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent Person (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013).

Coinsurance is a Cost-Sharing method that requires a Covered Person to pay a stated percentage of medical or pharmaceutical expenses after the deductible amount, if any, is paid; Coinsurance rates may differ for different types of services under the same Health Benefits Plan.

Complaint means the first time we are made aware of an issue of dissatisfaction that is not complex in nature. For more complex issues of dissatisfaction see definition for **Grievance**.

Continuous Quality Improvement means ongoing and systematic efforts to measure, evaluate and improve a Health Insurance carrier's processes and procedures in order to continually improve the quality of Health Care Services provided to Covered Persons.

Contract means the Application and all forms submitted as the basis for issuance of this Subscriber Agreement (Agreement). This Agreement including the *Summary of Benefits and Coverage*, any supplements, Endorsements or riders, the Application, medical questionnaire (if applicable), the issued Identification Card, non-Group Membership Letter of Agreement constitute the entire Contract.

Copayment is a Cost-Sharing method that requires a Covered Person pay a fixed dollar amount when a medical or pharmaceutical service is received, with the Health Insurance carrier paying the allowed balance; there may be different Copayment amounts for different types of services under the same Health Benefits Plan.

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

Cost Sharing means a Copayment, Coinsurance, Deductible, or any other form of financial obligation of a Covered Person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the Health Benefits Plan.

Coverage/Covered means benefits extended under this Agreement, subject to the terms, conditions, limitations, and exclusions of this Agreement.

Covered Benefits means those Health Care Services to which a Covered Person is entitled under the terms of a Health Benefits Plan.

Covered Person or Enrollee means a Subscriber, policyholder or Subscriber's enrolled Dependent or Dependent's, or other individual participating in a Health Benefits Plan.

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

Culturally and Linguistically appropriate manner of notice means the notice that meets the following requirements:

- The Health Care Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language.
- The Health Care Insurer must provide, upon request, a notice in any applicable non-English language.
- The Health Care Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Health Care Insurer.

For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if **10%** or more of the population residing in the county is literate only in the same non-English language, as determined by the Department of Health and Human Services (HHS). The counties that meet this 10% standard, as determined by HHS, are found at **https://www.cms.gov/marketplace/about/oversight** and any necessary changes to this list are posted by HHS annually.

Custodial or Domiciliary Care means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's normal daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

Custom-fitted Prefabricated Orthosis means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

Cytologic Screening (PAP Smear) means a Papanicolaou test or liquid based cervical cytopathology, a Human Papillomavirus Screening test and a pelvic exam for symptomatic as well as asymptomatic female patients.

Deductible means a fixed dollar amount that a Covered Person may be required to pay during a benefit period before the Health Insurance carrier begins payment for Covered Benefits; Health Benefits Plans may have both individual and family deductibles and separate deductibles for specific services.

Dependent means any Member of a Subscriber's family who meets the requirements of the Eligibility, Enrollment and Effective Dates Section of this Agreement, who is enrolled as our Member, and for whom we have actually received an Application.

Developmental delay refers to a child who has not gained the developmental skills expected of them, compared to others of the same age. Delays may occur in the areas of motor function, speech and language, cognitive, play, and social skills.

Developmental disabilities refer to a developmental level or status that is attributable to a cognitive or physical impairment, or both, originating before **age 22**. Such an impairment is likely to continue indefinitely and results in substantial functional or adaptive limitations. Examples of developmental disabilities include but not limited to, intellectual disability, pervasive developmental disorders, learning disorders, developmental coordination disorder, communication disorders, cerebral palsy, epilepsy, blindness, deafness, mutism, and muscular dystrophy.

Diagnostic Breast Examination is a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

- Seen or suspected from a screening examination for breast cancer; or
- Detected by another means of examination

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Doctor of Oriental Medicine means a person licensed as a physician to practice acupuncture and oriental medicine with the ability to practice medicine and collaborate with other healthcare providers. A doctor of Oriental Medicine may serve as a PCP provided that they are 1) acting within their scope of practice as defined under the relevant state licensing law; 2) meeting the PHP eligibility criteria for healthcare practitioners who provide primary care; and 3) agreeing to participate and to comply with PHP's care coordination and referral policies.

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

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

Emergency Care means healthcare procedures, treatments, evaluations, or services delivered to a Covered Person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a Reasonable Layperson, to result in:

- Jeopardy to the person's physical or mental health; or
- To the health or safety of a fetus or pregnant person
- Serious impairment of bodily functions
- Serious dysfunction of any bodily Organ or part
- Disfigurement to the person

Emergency Medical Condition means an illness, injury, symptom or condition that is so serious that a Reasonable/Prudent Layperson, who is without medical training and who uses their experience and knowledge when deciding whether or not to seek Emergency Health Care Services would seek care right away to avoid severe harm.
Refer to **Reasonable/Prudent Layperson** definition in this Glossary.

Endorsement means a provision added to the Subscriber Agreement that changes its original intent.

Enrollee or Covered Person means a Subscriber, policyholder or Subscriber's enrolled Dependent or Dependents, or other individual participating in a Health Benefits Plan.

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

Excluded Services means Health Care Services that are not Covered Services and that we will not pay for.

Experimental or Investigational medical, surgical, other healthcare procedures or treatments, including drugs. As used in this Agreement, "Experimental" or "Investigational" as related to drugs, devices, medical treatments or procedures means:

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

Eye Refraction means the measurement of the degree of refractive error of the eye by an eye care specialist for the determination of a prescription for eyeglasses or contact lenses.

Family, Infant and Toddler (FIT) Program means an early intervention services program provided by the Healthy Family and Children's Health Care Services to eligible children and their families.

FDA means the United States Food and Drug Administration.

FDA regulated Legend Drugs The Food, Drug, and Cosmetic Act (FDCA) defines prescription drugs, also known as "legend drugs" or "Rx drugs," as those that are not safe for use except under the supervision of a licensed practitioner.

Formulary, A drug *Formulary*, or preferred drug list, means the list of prescription drugs covered by a policy, plan, or certificate of health insurance, and the tier level at which each drug is Covered under this Plan. Presbyterian Health Plan's Pharmacy and Therapeutics Committee continually update this listing. For the most up-to-date *Formulary* drug information visit **https://client.formularynavigator.com/Search.aspx?siteCode=0324498195**.

Generic Drug is a drug approved by the FDA as having the same active ingredient and may be substituted for the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Genetic Inborn Errors of Metabolism (IEM) means a rare, inherited disorder that is present at birth and results in death or mental disability if untreated and requires consumption of Special Medical Foods. Categories of IEMs are as follows:

- Disorders of protein metabolism (i.e., amino acidopathies such as PKU, organic acidopathies, and urea cycle defects)
- Disorders of carbohydrate metabolism (i.e., carbohydrate intolerance disorders, glycogen storage disorders, disorders of gluconeogenesis and glycogenolysis)
- Disorders of fat metabolism

Good Cause means nonpayment of premium, fraud or a cause for cancelation or a failure to renew which the Superintendent of Insurance of the state of New Mexico has not found to be objectionable by regulation.

Grievance means any expression of dissatisfaction from any Member, the Member's Representative, or a Practitioner/Provider representing a Member.

Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or Practitioner/Provider, acting on behalf of that person with that person's consent, entitled to receive healthcare benefits provided by the healthcare plan.
- An individual, or that person's authorized representative, who may be entitled to receive healthcare benefits provided by the healthcare plan.
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Health Care Purchasing Act.

Habilitative Services means services that help a person learn, keep, or improve skills and functional abilities they may not be developing normally.

Health Benefits Plan means a policy or Agreement entered into, offered or issued by a Health Insurance carrier to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services.

Health Care Facility means an institution providing Health Care Services, including a Hospital or other licensed Inpatient center; an ambulatory surgical or treatment center; a Skilled Nursing Facility; a Residential Treatment Center, a Home Health Agency; a diagnostic laboratory or imaging center; and a Rehabilitation Facility or other therapeutic health setting.

Health Care Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit healthcare plan, fraternal benefit society, vision plan, or prepaid dental plan.

Health Care Professional means a physician or other healthcare Practitioner, including a pharmacist or Practitioner of the Healing Arts, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

Health Care 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 mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

Health Maintenance Organization (HMO) means a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover Out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Hearing Aid means Durable Medical Equipment that is of a design and circuitry to optimize audibility and listening.

Hearing Officer, Independent Co-Hearing Officer or ICO means a healthcare or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and Coverage issues that arise in external review hearings.

Home Health Agency means a facility or program, which is licensed, certified or otherwise authorized pursuant to state laws as a Home Health Agency.

Home Health Care Services means Health Care Services provided to a Member confined to the home due to physical illness. Home Health Care Services and home intravenous services and supplies will be provided by a Home Health Agency at a Member's home when prescribed

by the Member's Practitioner/Provider and we approve a **Prior Authorization** request for such services.

Hospice means a duly licensed facility or program, which has entered into an agreement with us to provide Health Care Services to Members who are diagnosed as terminally ill.

Hospital means an acute care general hospital, which;

- Has entered into an agreement with us to provide Covered Hospital Services to our members.
- Provides Inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed Practitioners/Providers.
- Is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.
- Is duly licensed to operate as an acute care general Hospital under applicable state or local law.
- Facility offering Inpatient services, nursing and overnight care for **three** or more individuals on a **24-hours**-a-day, **seven-days**-a-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

Human Papillomavirus Screening means a test approved by the FDA for detection of the Human Papillomavirus.

Identification Card (ID or Card) means the card issued to a Subscriber (Member) upon our approval of an Application that identifies you as a Covered Member of your Health Benefits Plan.

Immunosuppressive Drugs means Prescription Drugs/Medications used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include but not limited to:

- Preventing transplant rejection
- Supplementing chemotherapy
- Treating certain diseases of the immune system (i.e., “autoimmune” diseases)
- Reducing inflammation
- Relieving certain symptoms
- Other times when it may be helpful to suppress the human immune response

Independent Quality Review Organization (IQRO) means an organization independent of the Health Care Insurer or managed healthcare organization that performs external quality audits of Managed Health Care Plans and submits reports of its findings to both the Health Care Insurer and the managed healthcare organization and to the Division.

In-network Pharmacy means any duly licensed pharmacy, which has entered into an agreement with us to dispense Prescription drugs/Medications to our Members.

In-network Physician means any licensed Practitioner of the healing arts acting within the scope of their license who has entered into an agreement directly with us to provide Health Care Services to our Members.

In-network Practitioner/Provider means a Practitioner/Provider who, under a contract or through other arrangements with us, has agreed to provide Health Care Services to Covered Persons, known as Members, with an expectation of receiving payment, other than Cost-Sharing Deductibles, Coinsurance and/or Copayments, directly or indirectly from us.

Inpatient means a Member who has been admitted by a healthcare Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for which there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital. This may also be known as Hospitalization.

Long-term Therapy or Rehabilitation Services means therapies that the Member's Practitioner/Provider, in consultation with us, does not believe will likely result in Significant Improvement within a reasonable number of visits. Long-term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which Rehabilitation Services produce minimal or temporary change or relief. Chronic conditions include but not limited to, Muscular Dystrophy, Down Syndrome and Cerebral Palsy.

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

Managed Care means a system or technique(s) generally used by third-party payors or their agents to affect access to and control payment for Healthcare Services. Managed Care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services;
- Contracts with selected healthcare Providers;
- Financial incentives or disincentives for Covered Persons to use specific Providers, services, prescription drugs, or service sites;
    - Financial incentives offered are on a uniform availability and non-discriminatory basis. Any financial incentives offered are not intended to be a rebate for inducement.
- Controlled access to and coordination of healthcare services by a case manager; and
- Payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

Managed Health Care Plan (MHCP or Plan) means a health benefit plan offered by a healthcare insurer that provides for the delivery of comprehensive basic healthcare services and medically necessary services to individuals enrolled in the plan through its own employed health care providers or by contracting with selected or participating healthcare providers. A managed healthcare plan includes only those plans that provide comprehensive basic healthcare services to enrollees on a prepaid, capitated basis, including the following:

- Health maintenance organizations;
- Preferred provider organizations;
- Individual practice associations;
- Competitive medical plans;
- Exclusive provider organizations;
- Integrated delivery systems;
- Independent physician-provider organizations;
- Physician hospital-provider organizations; and
- Managed care services organizations.

Maternity Benefits means Covered Benefits for prenatal, intrapartum, perinatal or postpartum care.

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

Medicare Allowable means the maximum dollar amount that an insurer will consider reimbursing for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the provider as it may be reduced by any coinsurance, deductible or amount beyond the annual maximum.

Medical Drugs (Medications obtained through the medical benefit): Medical drugs are defined as medications administered in the office or facility that require a Healthcare Professional to administer. They may involve unique distribution and may be required to be obtained from our specialty pharmacy vendor. The office administered applies to all Outpatient settings including, but not limited to, physician's offices, infusions suites, emergency rooms, Urgent Care facilities and Outpatient surgery facilities. Medical Drugs may require a **Prior Authorization**, and some must be obtained through the specialty network.

Medical Director means a licensed physician in New Mexico, who oversees our Utilization Management Program and Quality Improvement Program, that monitors access to and appropriate utilization of Health Care Services and that is responsible for the Covered medical services we provide to you as required by New Mexico law.

Medical Necessity or Medically Necessary means Health Care Services determined by a Provider, in consultation with the Health Insurance carrier, to be appropriate or necessary, according to:

- Any applicable generally accepted principles and practices of good medical care
- Practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or
- Any applicable clinical protocols or practice guidelines developed by the Health Insurance carrier consistent with such federal, national, and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury, or disease.

Medicare means Title 18 of the Social Security Amendments of 1965, "Health Insurance for Aged and Disabled," as then constituted or later amended.

Medicare Eligible means people **age 65** and older, people under **age 65** with certain illnesses or disability and people of any age with kidney disease that require kidney dialysis or kidney transplant.

Member means the Subscriber or Dependent eligible to receive Covered Benefits for Health Care Services under this Agreement. Also known as an Enrollee.

Mental health or Substance Use Disorder services: are professional services, including Inpatient and Outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including Substance Use Disorder. Additionally, professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act [Chapter 61, Article 9A NMSA 1978].

National Health Care Network means Out-of-network Practitioners/Providers, including medical facilities, with whom we have arranged a discount for Health Care Service(s) provided out-of-state.

Nurse Practitioner means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a Certified Nurse Practitioner pursuant to the Nursing Practice Act.

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

Observation Services means Outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under Outpatient observation stay, it is on the Practitioners/Providers written order. Our level of care criteria must be met in order to transition from Observation Services to an Inpatient admission. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient status. Medical criteria will also be considered. Observation for greater than **24 hours** will require **Prior Authorization** by the facility.

Obstetrician/Gynecologist/OB-GYN means a Physician who is eligible to be or who is board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

Organ means an independent body structure that performs a specific function.

Organ Transplant includes parts or the whole of organs, eyes, or tissues.

Orthopedic Appliances/Custom Orthotic Device/Orthosis means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports or eliminates motion of a weak or diseased body part. Examples of Orthopedic Appliances are functional hand or leg brace, Milwaukee Brace, or fracture brace.

Orthotic Appliance means an external device intended to correct any defect of form or function of the human body.

Out-of-network Practitioner/Provider
means a healthcare Practitioner/Provider, including medical facilities, who has not entered into an agreement with us to provide Healthcare Services to our Members.

Out-of-network Services means Health Care Services obtained from an Out-of-network Practitioner/Provider as defined above.

Out-of-pocket Maximum means the most that a Member will pay, in total Cost Sharing, during the Contract Year. Once a Member has reached the Annual Out-of-pocket Maximum limit, we will pay **100%** of the Medicare Allowable. The Annual Out-of-pocket Maximum includes Deductible, Coinsurance, Copayments and Cost Sharing (including **Self-Administered Specialty Drugs**) and does not include non-covered charges including charges incurred after the benefit maximum has been reached. Covered charges for In-network Practitioner/Provider services do not apply to the Out-of-network Practitioner/Provider Annual Out-of-pocket

Maximum, and Covered charges for Out-of-network Practitioner/Provider services do not apply to the In-network Practitioner/Provider Annual Out-of-pocket Maximum.

Over-the-counter (OTC) means a drug for which a prescription is not normally needed.

Palliative Care means specialized medical care for people with serious illnesses. It is provided by an interdisciplinary team of clinicians and other specialists, who work with the member's other providers to provide an extra layer of support.

Personal Representative means a parent, guardian, or other person with legal authority to act on behalf of an individual in making decisions related to healthcare.

Pharmacist: A pharmacist may order, test, screen, treat and provide preventative services for health conditions or situations that include:

- Influenza;
- Group A streptococcus pharyngitis;
- SARS-COV-2;
- Uncomplicated urinary tract infection;
- Human immunodeficiency virus, limited to the provision of pre-exposure prophylaxis and post-exposure prophylaxis; and
- Other emerging and existing public health threats identified by the board or department of health during civil or public health emergencies.

Pharmacy Benefits Management means a service provided to or conducted by a health plan as defined in Section 59A-16-21.1 NMSA 1978 or health insurer that involves:

- Prescription drug claim administration;
- Pharmacy network management;
- Negotiation and administration of prescription drug discounts, rebates and other benefits;
- Design, administration or management of prescription drug benefits;
- *Formulary* management;
- Payment of claims to pharmacies for dispensing prescription drugs;
- Negotiation or administration of contracts relating to pharmacy operations or prescription benefits; or
- Any other service determined by the superintendent as specified by rule to be a pharmacy benefits management activity.

PHP means Presbyterian Health Plan, a corporation organized under the laws of the state of New Mexico.

Virtual Care means a virtual visit with a contracted Walmart Health Virtual Care provider. These visits are scheduled through the myPRES portal.

PPACA means Patient Protection And Affordable Care Act.

Physician means any licensed Practitioner of the healing arts acting within the scope of their license.

Physician Assistant (PA) means a skilled person who is a graduate of a Physician Assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Physician Assistants, and who is licensed to practice medicine, usually under the supervision of a licensed Physician.

Practitioner of the Healing Arts means a Health Care Professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

Practitioner/Provider means any licensed Practitioner of the healing arts acting within the scope of their license.

Practitioner/Provider Assistant means a skilled person who is a graduate of a Practitioner/Provider Assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Practitioner/Provider Assistants, and who is licensed in the state of New Mexico to practice medicine under the supervision of a licensed Practitioner/Provider.

Preferred (as it refers to medication and diabetic supplies) means medication that is selected for inclusion on Preferred tiers of the *Formulary* based on clinical efficacy, safety, and financial value.

Premium means the amount paid for a Contract of health insurance.

Prepayment means the monthly amount of money we charge payable in advance for Covered Benefits provided under this Agreement.

Prescription Drugs/Medications are drugs that, by federal law, require a Practitioner's/Provider's prescription for dispensing of a medication. The Food and Drug Administration Modernization Act of 1997 requires an Rx symbol must be printed on the medicine's label and/or contain the language "Caution: Federal law prohibits dispensing without prescription. The prescription requirement limits the potential of misuse, harm, or adverse effects if not used under the direct supervision of a licensed healthcare professional."

Primary Care Provider/Physician/Practitioner (PCP) means a Health Care Professional who, within the scope of the professional license, supervises, coordinates, and provides initial and basic care to Covered Persons; who initiates the patient's referral for

specialist care, and who maintains continuity of patient care. PCPs include General Practitioners, Family Practice Physicians, Geriatricians, Internists, Pediatricians, and Obstetricians / Gynecologists, Physician Assistants and Nurse Practitioners. **Pursuant** to 13.10.21.7 NMAC, other Health Care Professional may also serve as PCPs.

Prior Authorization means a preservice determination made by a Health Insurance carrier regarding a Covered Person's eligibility for Health Care Services based on Medical Necessity, health benefits coverage and the appropriateness and site of services pursuant to the terms of the Health Benefits Plan.

Prosthetic Device means an artificial device to replace a missing part of the body.

Provider means a licensed Health Care Professional, hospital or other facility authorized to furnish health care services.

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

Reasonable/Prudent Layperson means a person who is without medical training and who uses their experience and knowledge when deciding whether or not to seek Emergency Health Care Services. A Reasonable/Prudent Layperson is considered to have acted "reasonably" if, after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention (including healthcare procedures, treatments, or services) could reasonably be expected to result in:

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

Reconstructive Surgery means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery.
- Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

Registered Lay/Licensed Midwife means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

Rehabilitation Facility means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

Rehabilitation Services means Health Care Services that help a Member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a Member was sick, injured or disabled. These services may include physical and occupational therapy, and speech-language pathology in a variety of Inpatient and/or Outpatient settings.

Rescission of Coverage means a cancelation or discontinuance of Coverage that has retroactive effect. A cancelation or discontinuance of coverage is not a rescission if:

- The cancelation or discontinuance of Coverage has only a prospective effect, or
- The cancelation or discontinuance of Coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums, Prepayments or contributions towards the cost of Coverage.

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available **24 hours** a day.

Screening Mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic Members and includes the X-ray examination of the breast using equipment that is specifically for mammography, including the X-ray tube, filter, compression device, screens, film, and cassettes, and that has a radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast. Screening Mammography includes the professional interpretation of the film but does not include diagnostic mammography.

Self-Administered Specialty Drugs (Tier 5 Medications obtained through the Prescription Drug/Medication pharmacy benefit): Self-Administered Specialty Drugs are self-administered, meaning they are administered by the patient, a family member or caregiver. Self-Administered Specialty Drugs are often used to treat complex chronic, rare diseases and/or life-threatening conditions. Most Self-Administered Specialty Drugs require **Prior Authorization** and must be obtained through the specialty pharmacy network. Self- Administered Specialty Drugs are often high cost, typically greater than **$600** for a **30-day** supply.

Self-Administered Specialty Drugs are not available through the mail order option and are limited to a **30-day** supply. Certain Self-Administered Specialty Drugs are limited to an initial fill up to a **14-day** supply to ensure patients can tolerate the new medication. For a complete list of these drugs, please see the Health Insurance Exchange Metal Level Plan *Formulary* list at **www.phs.org**. The medications listed on the *Formulary* are subject to change pursuant to the management activities of Presbyterian Health Plan. You can call our Presbyterian Customer

Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7528** or **1-855-923-7528**. Hearing impaired users may call **TTY 711**.

Serology - the examination of antibodies and other substances in the serum (clear liquid part of the blood). Serology tests are used to look for the presence of antibodies in the blood that show whether a person has been exposed to a virus or other infectious agent.

Service Area means the geographic area in which we are authorized to provide services as a Health Maintenance Organization and includes the entire state of New Mexico.

Short-term Rehabilitation means Rehabilitation Services and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected. See *Summary of Benefits and Coverage* for the number of visits.

Significant Improvement means that:

- The patient is likely to meet all therapy goals for a reasonable number of visits of therapy or
- The patient has met all therapy goals in the preceding visits of therapy, as specifically documented in the therapy record.

Skilled Nursing Facility means an institution that is licensed under state law to provide skilled care nursing care services and has entered into an agreement with PHP to provide Covered Services to our Members.

Special Medical Foods means nutritional substances in any form that are used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require **Prior Authorization** through Presbyterian's Pharmacy Department.

Specialty Pharmacy: Presbyterian's In-network Pharmacy vendor that, under contract or other arrangement with us, provides Covered **Self- Administered Specialty Drugs** to Members.

Spouse: Legally married husband or wife.

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

Subscriber means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the Health Benefits Plan or in the case of an individual Contract, the Person in whose name the Contract is issued.

Subscriber Agreement means the booklet which describes the Covered Benefits, including the terms, limitations and exclusions, for which the Member and their eligible Dependents (if any) are eligible.

Substance Use Disorder means dependence on or abuse of substances meeting the criteria as stated in the DSM-5 for these disorders.

Summary of Benefits means a summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective Subscriber or Covered Person by the Health Insurance carrier.

Superintendent means The Superintendent of Insurance, the Office of Superintendent of Insurance (OSI), or employees of OSI acting with the Superintendent's authorization.

Supplemental Breast Examination is a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

- Used to screen for breast cancer when there is no abnormality seen or suspected; and
- Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

Surprise Bill is an unexpected bill from a healthcare provider or facility. This can happen when a person with health insurance unknowingly gets medical care from a provider or air ambulance services outside their health plan's network. Surprise billing happens in both emergency and nonemergency care settings.

Telemedicine means the use of telecommunications and information technology to provide clinical healthcare from a distance. Telemedicine allows healthcare professionals to evaluate, diagnosis 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.

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

Termination of Coverage means the cancelation or non-renewal of Coverage provided by a Health Care Insurer to a Covered Person/Grievant but does not include a voluntary termination by a Covered Person/Grievant or termination of the Health Benefits Plan that does not contain a renewal provision.

Tertiary Care Facility means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Tobacco means cigarettes (including roll-your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, chuttas, and dhumti), pipe, smokeless Tobacco (including snuff, chewing Tobacco and betel nut), and novel Tobacco products, such as *eclipse*, *accord* or other low-smoke cigarettes.

Tobacco Cessation Counseling/Program means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow up.
- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying a Member's attendance.
- Employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities.
- Uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

Total Allowable Charges means, for In-network Practitioners/Providers, the Total Allowable Charges may not exceed the amount the Practitioner/Provider has agreed to accept from us for a Covered service. For Out-of-network Practitioners/Providers, the Total Allowable Charges may not exceed Medicare Allowable Charge as we determine for a service.

Traditional Fee-for-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Covered Persons/Grievants to utilize preferred (In-network) Practitioners/Providers, to follow pre-authorization (**Prior Authorization**) rules, to utilize Prescription Drug Formularies or other cost-saving procedures to obtain Prescription Drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

Trauma Spectrum Disorders include posttraumatic stress disorder (PTSD), a subgroup of major depression, borderline personality disorder (BPD) and dissociative disorders; they share in

common a neurobiological footprint and are distinguished from other disorders that may share symptom similarities, like some of the anxiety disorders, but are not as clearly linked to stress.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by a Health Care Insurer consistent with the federal, national, and professional practice guidelines that are used by a Health Care Insurer in determining whether to certify/authorize or deny a requested Health Care Service.

Urgent Care Situation means a situation in which a Prudent Layperson in that circumstance, possessing an average knowledge of medicine and health would believe that they do not have an emergency medical condition but needs care expeditiously because:

- The life or health of the Covered Person would otherwise be jeopardized;
- The Covered Person's ability to regain maximum function would otherwise be jeopardized;
- In the opinion of a physician with knowledge of the Covered Person's medical condition, delay would subject the Covered Person to severe pain that cannot be adequately managed without care or treatment;
- The medical exigencies of the case require expedited care; or
- The Covered Person's claim otherwise involves urgent care.

Urgent Care Center means a facility operated to provide Health Care Services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Utilization Review means a system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

Virtual Care means a virtual visit with a contracted Virtual Care provider. These visits are scheduled through the myPRES portal.

Vocational Rehabilitation means services which are required in order for the individual to prepare for, enter, engage in, retain or regain employment.

Well-child Care means routine pediatric care and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

Women's Health Care Practitioner/Provider means any Practitioner/Provider who specializes in Women's Health Care and who we recognize as a Women's Health Care Practitioner/Provider.

This Subscriber Agreement is issued to the Subscriber named in an Application received and accepted by Presbyterian Health Plan, a New Mexico corporation. The terms and conditions appearing herein and any applicable amendments are part of this Subscriber Agreement.

IN WITNESS THEREOF, Presbyterian Health Plan has caused this Subscriber Agreement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN

Tony Hernandez
President
Presbyterian Health Plan, Inc

Notice of Availability

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.
Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.
Navajo Diné	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-855-592-7737 (TTY:711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
Vietnamese Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-592-7737 (Người khuyết tật: TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
German Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-592-7737 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
Chinese Simplified 简体中文	注意：如果您使用简体中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以提供无障碍格式版信息。请拨打 1-855-592-7737 (TTY: 711) 或咨询您的服务提供者。
Chinese Traditional 繁體中文	注意：如果您使用繁體中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務，以提供無障礙格式版資訊。請致電 1-855-592-7737 (TTY:711) 或諮詢您的服務提供者。
Japanese 日本語	注:日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-592-7737（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。
Filipino	ATTENTION: Kung marunong kang magsalita ng Filipino, makakagamit ka ng mga libreng serbisyo sa tulong sa wika. Ang mga angkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Korean 한국어	주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-855-592-7737(TTY: 711)로 전화하거나 서비스 제공업체에 문의하세요.
French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations

PRESBYTERIAN

	dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-592-7737 (TTY: 711) или обратитесь к своему поставщику услуг.
Urdu اردو	توجہ دیں: اگر آپ اردو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ 1-855-592-7737 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. ومتاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم 1-855-592-7737 (TTY: 711) (خدمة الهاتف النصي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DİKKATİNİZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.

[Place Holder for upcoming Flyers]

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Presbyterian Healthcare Services does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by phone, mail, fax, or email at:

Mailing Address: Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone/TTY: **1-866-977-3021**, **TTY 711**

Fax: **(505) 923-5124**

Email: **info@phs.org**

If you need help filing a grievance, the Presbyterian Privacy Officer and Civil Rights Coordinator is available to help you.

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:

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

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

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

This notice is available at Presbyterian Healthcare Services website: **www.phs.org/nondiscrimination**.

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Aviso de no discriminación y accesibilidad

La ley prohíbe la discriminación

Presbyterian Healthcare Services cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad o sexo incluidas las características sexuales, incluidos los rasgos intersexuales; embarazo o condiciones relacionadas; orientación sexual; identidad de género y estereotipos de género). Presbyterian Healthcare Services no excluye a las personas ni las trata menos favorablemente por motivos de raza, color, origen nacional, edad, discapacidad o sexo.

Presbyterian Healthcare Services:

- Proporciona a las personas con discapacidades modificaciones razonables y ayuda y servicios auxiliares adecuados y gratuitos para comunicarse eficazmente con nosotros, tales como:
  - Intérpretes calificados de lenguaje de señas.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, entre otros).
- Ofrece servicios gratuitos de asistencia lingüística a personas cuyo idioma principal no es el inglés, lo que puede incluir:
  - Intérpretes calificados.
  - Información escrita en otros idiomas.

Si necesita modificaciones razonables, ayudas y servicios auxiliares apropiados o servicios de asistencia lingüística, comuníquese con Presbyterian Customer Service Center al **(505) 923-5420, 1-855-592-7737, TTY 711**.

Si cree que Presbyterian Healthcare Services no ha proporcionado estos servicios o ha discriminado de otra manera por motivos de raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja en persona o por correo, fax o correo electrónico a:

Dirección postal: Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125-7489

Teléfono/TTY: **1-866-977-3021**, **TTY 711**

Fax: **(505) 923-5124**

Correo electrónico: **info@phs.org**

Si necesita ayuda para presentar una queja, el Presbyterian Privacy Officer y Civil Rights Coordinator [Coordinador de Derechos Civiles y Funcionario de Privacidad de Presbyterian] está disponible para ayudarlo.

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. electrónicamente a través del portal de quejas de la Oficina de Derechos Civiles, disponible en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, o por correo o teléfono a:

Dirección postal: Departamento de Salud y Servicios Humanos (Estados Unidos) (DHHS)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

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

Los formularios de queja están disponibles en **http://www.hhs.gov/ocr/office/file/index.html**.

Este aviso está disponible en el sitio web de Presbyterian Healthcare Services: **www.phs.org/nondiscrimination**.

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Notice of Availability

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.
Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.
Navajo Diné	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-855-592-7737 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
Vietnamese Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-592-7737 (Người khuyết tật: TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
German Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-592-7737 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
Chinese Simplified 简体中文	注意：如果您使用简体中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以提供无障碍格式版信息。请拨打 1-855-592-7737 (TTY: 711) 或咨询您的服务提供者。
Chinese Traditional 繁體中文	注意：如果您使用繁體中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務，以提供無障礙格式版資訊。請致電 1-855-592-7737 (TTY:711) 或諮詢您的服務提供者。
Japanese 日本語	注:日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-592-7737(TTY:711)までお電話ください。または、ご利用の事業者にご相談ください。
Filipino	ATTENTION: Kung marunong kang magsalita ng Filipino, makakagamit ka ng mga libreng serbisyo sa tulong sa wika. Ang mga angkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Korean 한국어	주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-855-592-7737(TTY: 711)로 전화하거나 서비스 제공업체에 문의하세요.

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French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-592-7737 (TTY: 711) или обратитесь к своему поставщику услуг.
Urdu اردو	توجہ دیں: اگر آپ اردو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ 1-855-592-7737 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. ومتاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم 1-855-592-7737 (TTY: 711) (خدمة الهاتف النصي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DİKKATİNİZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.