PRESBYTERIAN

Presbyterian Health Plan, Inc.

Group Subscriber Agreement and Guide to Your

Presbyterian Health Plan, Inc.

Group Metal Benefit Plans
HMO HDHP HSA

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

MPC122518
01.01.2026-12.31.26
PBHP-134466391

PHP_GSA_HMO_HIX_HDHP_ 2026

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

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

Phone:
(505) 923-5678 or
1-800-356-2219
TTY 711

Prior Authorization

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

Phone:
(505) 923-5678 or
1-800-356-2219

Appeals and Grievances

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

Phone:
(505) 923-5678 or
1-800-356-2219
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 Group 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

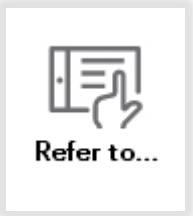
Throughout this Agreement, we ask you to refer to your *Summary of Benefits and Coverage*. The *Summary of Benefits and Coverage* is a chart that shows some specific Covered Benefits this Plan provides, the amount you may have to pay (Cost Sharing) and the Coverage **Limitations and Exclusions**.

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 to choose or change your Primary Care Physician (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.

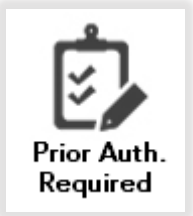
Understanding This Agreement

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.

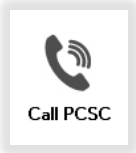
Call Presbyterian Customer Service Center – This "Call PCSC" symbol appears whenever we refer to our Presbyterian Customer Service Center or to remind you to call us for information.

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) 923-5678** or **1-800-356-2219**. Hearing impaired users may call the **TTY** line at **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) 923-5678** or **1-800-356-2219.** Hearing impaired users may call the **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 **https://www.phs.org/member-rights**.

Member Rights

The Group Subscriber Agreement (GSA) 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 Healthcare Services, and for other Healthcare 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 his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of our position on treatment options; if the Covered Person is not capable of understanding the information, the explanation shall be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the Covered Person's medical record;
- 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 his or her next of kin,

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

- All the rights afforded by law, rule, or regulation as a patient in a licensed Healthcare Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Covered Person understands;
- Prompt notification, as required in this rule, of termination or changes in benefits, services or Practitioner/Provider network;
- File a Grievance or Appeal with us or the Superintendent and to receive an answer to those Grievances 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.

Additional Member Rights and Responsibilities

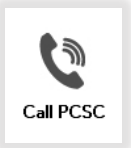
In addition to the rights and responsibilities afforded you by the state, we provide our Members with the following additional rights to:

- Receive information about our organization, our services and benefits, how to access Healthcare Services, our Practitioners and Providers, and your rights and responsibilities;

- Have a clear, private and candid discussion about appropriate or Medically Necessary treatment options for your medical condition regardless of cost or benefit Coverage;
- Participate with your Practitioner/Provider in making decisions about your healthcare;
- Refuse care, treatment, medication or a specific Practitioner/Provider, after the consequences of your decision have been explained in a language that you understand;
- Seek a second opinion for surgery from another In-network Practitioner/Provider when you need additional information regarding recommended treatment or requested care;
- Receive Healthcare Services in a non-discriminatory fashion. This means that you may not be denied Covered Services on the basis of race, color, sex, sexual orientation, 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:

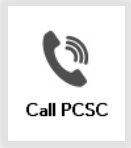
- Provide, whenever possible, the information that we and your Practitioners/Providers need in order to provide services or care and to oversee the quality of those services or care;
- Follow the plans and instructions for care that you have agreed upon with your treating Practitioner/Provider. You may, 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 Group Subscriber Agreement (GSA) and if you have questions, contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219** 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, phone 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; and
- 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) 923-5678** or **1-800-356-2219**. 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 Primary Care Practitioner to get Healthcare 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.

This plan is a fully qualified High-Deductible Health Plan (HDHP) which means that you must meet an individual or family Deductible before any benefits (including pharmacy benefits) are paid out by PHP. Once the Deductible is met, you will be required to pay a Coinsurance (in most cases) or portion of the cost of the Covered services that are provided. This is explained in greater detail in the General Information Section.

Preventive benefits, as defined by the Affordable Care Act (ACA) are not subject to the Deductible. This means you can access this benefit and the plan will pay even if you have not met the individual or family Deductible. Please see the **Clinical Preventive Services** benefit on your *Summary of Benefits and Coverage* for further information. Prescription Drugs are not part of the Clinical Preventive Services benefit and thus, are subject to the Deductible and Coinsurance listed in the *Summary of Benefits and Coverage*.

This Plan is qualified for use in conjunction with a Health Savings Account (HSA). Please see the HSA Note(s) posted throughout this document. Please remember, though, that this booklet describes only the medical/surgical benefits available to you. HSAs are not administered by PHP and are regulated by the United States Department of the Treasury (United States Treasury). For more information, please see the United States Treasury's website at: **https://home.treasury.gov/**.

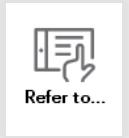
PHP accepts premium and Cost-Sharing payments from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or Cost Sharing): a Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act, an Indian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

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**.

- All of your Healthcare Services are provided by In-network Contract Practitioner/Providers in our Service Area, except for Urgent and Emergency Healthcare Services situations. Please refer to the Benefits Section **Accidental Injury (Trauma) / Urgent Care / Emergency Healthcare Services / Observation Services**.
- 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.

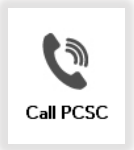


To receive care under our plan, you must select an In-network Primary Care Physician to manage your healthcare needs. Your Primary Care Physician will be able to meet most of these needs. A list of Practitioners/Providers who serve as In-network Primary Care Physicians may be found in the Provider Directory. Primary Care Physicians include, but are 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 Primary Care Physician any doctor or Nurse Practitioner on that list.

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

Provider Directory

You will find our Primary Care Physicians close to where you live and work across the State. The Provider Directory is available on our website at **https://www2.phs.org/providers?insurance_plans=engage**.



If you need additional information about a Provider or would like to report an inaccuracy in the Provider Directory, you may call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219**. 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?directory_type=php&insurance_plans=ENGAGE** and by navigating to the identified Provider's details page and choosing the *Report Inaccuracies* option.

The Provider Directory is subject to change, and you should always verify the Practitioner/Provider's network status by visiting our website at **https://www2.phs.org/providers?insurance_plans=engage**. 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 your In-network Cost-Sharing amount for care received from that Provider. Please refer to the **Summary of Health Insurance Grievance Procedures Section** to understand your rights for filing an appeal.

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 Primary Care Physician (PCP) to manage your healthcare needs. Primary Care Physicians include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians and Obstetricians/Gynecologists (if applicable).

Establishing a relationship with your Primary Care Physician 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 themself 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 Provider/Practitioner

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 Provider/Practitioner, 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 a primary care physician, for choosing a women's healthcare provider as her PCP.

Specialist Care

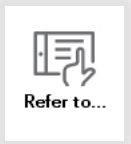
As our Member, you must carefully follow all procedures and conditions for obtaining care from In-network specialists and/or Out-of-network Practitioners/Providers. Out-of-network are Covered for Emergency Care only or if Medically Necessary care is not reasonably available In-network. Continuity of care may also allow Out-of-network coverage for a temporary period. We no longer require a paper referral from your Primary Care Physician (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 Provider Office Hours

Most Providers offer an after-hours answering service. For nonemergency situations, you should phone your PCP. If needed, you can find your PCP's phone number in the Provider Directory. If Emergency Healthcare Services are needed, you should call 911, or seek treatment at an emergency room. If in need of Urgent Care, you may seek treatment at an Urgent Care Center that is available and open for business. Please note that some Urgent Care Centers are not open after 8 p.m. In such circumstances, it may be necessary to use an emergency room for care that is needed on an urgent basis. Please refer to the **Benefits Section, Accidental Injury (Trauma) / Urgent Care / Emergency Health Services / Observation Services Benefits Section** of this Agreement for a detailed description of Coverage for Urgent and Emergency Healthcare 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 Healthcare Services require our review and **Prior Authorization** before the services are provided. If you seek care from an In-network Practitioner/Provider, your In-network Practitioner/Provider will notify us and handle all aspects of your care. 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 Presbyterian Health Plan (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 Healthcare Services to PHP Members on this plan.

Covered Healthcare 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 urgent or 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 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 for urgent or 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.

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**.

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

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) 923-5678** or **1-800-356-2219**. We will try to the resolve the issue with the Provider on your behalf.
- If the problem has not been resolved by us, you can contact the New Mexico Office of Superintendent of Insurance at **www.osi.state.nm.us** or **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 **1-800-356-2219**. 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** and **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.

Restrictions on Services Received Outside of the PHP Service Area

Emergency Healthcare Services and/or Urgent Care services will be Covered. For Emergency Healthcare Services and/or Urgent Care services received, you may seek services from the nearest appropriate facility where Emergency Healthcare Services / Urgent Care services may be rendered. Cost Sharing and benefits for an Emergency Healthcare service rendered by a non-participating Provider shall be the same as if rendered by a participating Provider.

National Healthcare Practitioner/Provider Network

When receiving Urgent or Emergency Healthcare Services outside of the State of New Mexico area you can help reduce the cost of such services by seeking care from one of our National Healthcare Provider Network Practitioners/Providers. These cost savings can help minimize future premium increases.

For additional information regarding National Healthcare Practitioner/Providers please call our Presbyterian Customer Service Center prior to obtaining services Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219**. Hearing impaired users may call **TTY 711**.

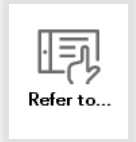
Cost Sharing – Your Out-of-pocket Costs

Many Healthcare Services you receive from In-network and Out-of-network Practitioners and Providers require some payment from you. We refer to these payments as Cost Sharing. These are your Out-of-pocket costs and may be Deductibles, Coinsurance and/or Copayment amounts. Cost Sharing and benefits for an emergency healthcare service rendered by a non-participating provider shall be the same as if rendered by a participating provider. Cost-Sharing and benefit limitations for medically necessary, non-emergent healthcare services rendered by a non-

participating provider at a participating facility where the covered person had no ability or opportunity to choose to receive the service from a participating provider 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 Presbyterian Customer Service Center that services will be covered prior to receiving non-emergent healthcare services from a non-participating provider.

Annual Contract Year Deductible

Certain services are subject to an Annual Contract Year Deductible. The Annual Contract Year Deductible is the amount you and your Covered Dependents must pay for Covered Healthcare Services each Contract Year before we begin to pay Covered Benefits for that Member. The Annual Contract Year Deductible may not apply to all Healthcare Services. Refer to 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*.

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) 923-5678** or **1-800-356-2219**. Hearing impaired users may call **TTY 711**.

Office Visit Copayment

If your Plan has an Office Visit Copayment, this is the amount of Cost Sharing you must pay each time you have an office visit with an In-network Practitioner/Provider. This Copayment is for the office visit only. All other services provided during the visit are subject to other Cost Sharing (Deductible and Coinsurance). Refer to **If you visit a healthcare provider's office or clinic** in your *Summary of Benefits and Coverage* for all Cost-Sharing Copayment, Deductible and Coinsurance amounts. Cost-Sharing and benefit limitations for a medically necessary, non-emergent 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 in 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) 923-5678** or **1-800-356-2219** and tell them you'd like to request a second opinion from an Out-of-network provider. PCSC 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 healthcare decisions on your behalf as well as medical services you do and do not want. These are documents you complete in advance and can share with your provider or person who will speak on your behalf. Sharing your advance directives with your healthcare team helps make your wishes clear. You can create an Advance Directive at our Presbyterian Website at **https://www.phs.org/tools-resources/patient/advance-directive**.

Prior Authorization

This Section explains what Covered Healthcare Services require Prior Authorization before you receive these services and how to obtain Prior Authorization. You can obtain further information through your PCP or at our website at https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000030435. If you have questions about a Prior Authorization submitted by your PCP/Provider, please contact us Monday through Friday from 7 a.m. to 6 p.m. at (505) 923-8469, or 1-866-597-7835. Hearing impaired users may call TTY 711.

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

What is Prior Authorization?

Prior Authorization is a clinical evaluation process to determine if the requested Healthcare Service is Medically Necessary, a Covered Benefit, and if it is being delivered in the most appropriate healthcare setting. Our Medical Director or other clinical professional will review the requested Healthcare Service in consultation with your medical provider, and if it meets our requirements for Coverage and Medical Necessity, it is Authorized (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 **PCP 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 the visit is an urgent or emergent situation as defined by your benefits. 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:

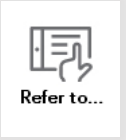
- Availability – The In-network Practitioner/Provider is not reasonably available to see you in a timely fashion as dictated by the clinical situation.
- Competency – The In-network Practitioner/Provider does not have the necessary training or expertise required to render the service or treatment.
- 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. 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 urgent or emergent situations as defined by your benefits. Presbyterian will provide material that contains in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, **limitations, exclusions**, conditions of eligibility and **Prior Authorization** requirements, within a reasonable time after enrollment and at subsequent periodic times as appropriate.

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

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) 923-5678** or **1-800-356-2219** 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**.

- All Hospital Inpatient Admissions
- Autologous Chondrocyte Implantation (Carticel)
- Bariatric Surgery (Weight Loss Surgery)
- Blepharoplasty/Brow Ptosis Surgery
- Breast Reconstruction following Mastectomy

- Breast Reduction for Gynecomastia
- Chimeric Antigen Receptor T-cell Therapy
- Clinical Trial
- Computed Tomography (CT)
- Corneal Cross-linking
- CT Angiography (CTA)
- CV: Mobile Cardiac Outpatient Telemetry (MCOT) and Real-time Continuous Attended Cardiac Monitoring Systems
- Detoxification – Inpatient Acute requiring medical intervention (alcohol/substance)
- Durable Medical Equipment (DME)
- Dialysis
- ENT: Rhinoplasty
- ENT: Tonsillectomy or tonsillectomy with adenoidectomy
- ENT: Endoscopy Nasal/Sinus: Surgical (Balloon Dilation)
- Gastric Electric Stimulation for Treatment of Chronic Gastroparesis
- Gender Affirming Surgical Intervention
- Genetic Testing
- GI: Wireless Capsule Endoscopy
- Hip Resurfacing Total
- Hip Replacement Total
- Gyn: Hysterectomy
- Hypoglossal Nerve stimulation
- Home Health Services
- Hormone Pellet Insertion, Subcutaneous
- Hospice
- Hyperbaric Oxygen
- Knee, Arthroscopy
- Knee Replacement Total
- Lumbar/Cervical Spine Surgery
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Ortho: Ankle – Total Ankle Replacement Surgery (Arthroplasty)
- Ortho: Knee – Meniscus Implant and Allograft / Meniscus Transplant
- Orthotics
- Outpatient Observation
- Pain: Epidural Corticosteroid Injections for Back Pain
- Plastic surgery: Panniculectomy and Abdominoplasty and Body Contouring Procedures
- Plastic Surgery: Restorative / Reconstructive / Cosmetic Surgery and Treatment
- Positron Emission Tomography (PET)
- Prescription Drugs/Medications

    - Please see the Presbyterian Health Insurance Exchange Metal Level *Formulary* list at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101**
- Proton Beam Irradiation
- Respite
- Sacral Nerve Stimulation for Urinary and Fecal Incontinence
- Scans & Cardiac Imaging including Echocardiogram
- Selected Surgical/Diagnostic procedures
    - Blepharoplasty/Brow Ptosis Surgery
    - Breast Reconstruction following Mastectomy
    - Breast reduction for gynecomastia
    - Endoscopy Nasal/Sinus balloon dilation
    - Gender Confirmational Surgery
    - Hysterectomy
    - Lumbar/Cervical Spine Surgery
    - Major endoscopic procedures
    - Meniscus Implant and Allograft/Meniscus Transplant
    - Operative and cutting procedures
    - Panniculectomy
    - Preoperative and postoperative care
    - Rhinoplasty
    - Tonsillectomy
    - Total Ankle Replacement
    - Total Hip Replacement
    - Total Knee Replacement
    - Varicose Vein Procedures
- Skilled Nursing Facility (SNF) Services
- Skin Substitutes (Tissue-Engineered/Bioengineered)
- Sleep Studies (In a Facility)
- Transplants: Bone marrow/stem cell transplant: Allogeneic, Autologous
- Transplants: Heart (includes ventricular assist and artificial heart devices.)
- Transplants: Heart and Lung
- Transplants: Kidney
- Transplants: Liver
- Transplants: Lung and Lobar Lung
- Transplants: Pancreas and Kidney
- Transplants: Pancreas Islet Cell
- Transplants: Procurement, Transportation
- Transplants: Small Bowel, Small Bowel/Liver
- Veins: Varicose Vein Procedures including Echo sclerotherapy
- Virtual Colonoscopy
- Water Vapor Thermal Therapy for LUTS/BPH
- X-STOP Interspinous Process Decompression

Authorizing Inpatient Hospital Admission following an Emergency

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

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.

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)

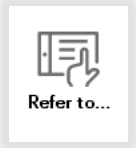
If your medical condition requires that we make a **Prior Authorization** decision quickly, we will notify you and your Practitioner/Provider of an expedited decision, within **24 hours** of our receipt of the written or verbal request for an expedited decision.

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 Healthcare Service is not Covered.
- An explanation of how you may request our internal review of our Adverse Determination including any forms that must be used and completed.



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

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

Prior Authorization

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:*

- Mental health or Substance Use Disorder services:
  - Acute or immediately necessary care
  - Acute episodes of chronic mental health or Substance Use Disorder conditions
  - Initial In-network Inpatient or Outpatient substance use treatment services
- Prescription drugs used for the treatment of Substance Use Disorders, when a generic version is available, the medication is medically necessary and is approved by the Federal Food and Drug Administration
- Emergency services
- Contraception services that are not subject to any Cost Sharing
- Obstetrical or gynecological ultrasound

However, 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 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.
- **Other Requests –** We will resolve all other requests within **seven business days**.

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

Why We Review

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

After Care Review

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

Behavioral Healthcare

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. A summary of the dispute resolution process is included in this document. Please refer to the Table of Contents. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

Record of Prior Authorization

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

Prescription drug Prior Authorization protocols

After January 1, 2014, a 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 Healthcare Benefit Plan offers Coverage for a wide range of Healthcare Services. This Section gives you the details about your benefits, and other requirements, Limitations and Exclusions.

Specifically Covered

This Healthcare Benefit Plan helps pay for healthcare expenses that are Medically Necessary and Specifically Covered in this Agreement. Specifically Covered means only those Healthcare 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 Healthcare Benefit Plan. All other benefits and services not specifically listed as Covered in the Benefits Section shall be **excluded, except for Clinical Preventive Health Services and except as required by state or federal law**.

There are no annual or lifetime limits on the dollar value of essential health benefits, as defined under the Affordable Care Act. Presbyterian Health Plan will not deny 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 Healthcare Service or supply is a specifically Covered Benefit. The fact that a Practitioner/Provider has prescribed, ordered, recommended, or approved a Healthcare Service or supply does not guarantee that it is a Covered Benefit even if it is not listed as an **Exclusion**.

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

Medical Necessity

This Healthcare 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 Healthcare 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 Healthcare 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.

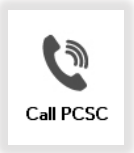
PresRN

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 our website at **www.phs.org**. Members can also call our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**, 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

Wellness at Work is an online tool for members. It is your personal well-being portal that provides access to a health check assessment, well-being journeys, challenges, healthy habit tracking, tobacco cessation (Powered by EX Program by Truth Initiative) and other resources such as healthy recipes and sleep guides. To participate, visit **www.phs.org** and register or login to myPRES.

Covered Benefits

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

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

Urgent Care

This 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 Healthcare Services

This Agreement covers acute Emergency Healthcare 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 Healthcare Service is appropriate will be determined by the Reasonable/Prudent Layperson standard discussed below.

We will provide reimbursement when you receive healthcare procedures, treatments or services, 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 reasonably be expected by a reasonable layperson to result in:

- Jeopardy to the person's physical or mental health
- 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

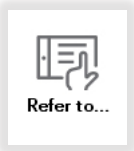
- Any circumstance that prevented you from using our established procedures for obtaining Emergency Healthcare Services

Coverage for trauma services and all other Emergency Healthcare Services will continue at least 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 in consultant with us and in accordance with federal law.

We will provide reimbursement when you, acting in good faith, obtain Emergency Healthcare Services for what reasonably appears to you, acting as a Reasonable/Prudent Layperson, to be an acute condition that requires immediate medical attention, even if your condition is later determined to not be an emergency.

Prior Authorization is not required for Emergency Healthcare Services. If you are admitted as an Inpatient to the Hospital, you or your Practitioner needs to notify us 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 your *Summary of Benefits and Coverage* for the required Cost Sharing.

For Emergency Healthcare Services received Out-of-network and/or outside of New Mexico (our Service Area), you may seek Emergency Healthcare Services from the nearest appropriate facility where Emergency Healthcare 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 Healthcare 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 Healthcare Services, and Observation Services** whether provided within or outside of our Service Area are subject to the **Limitations** listed in the **Limitations Section** and the **Exclusions listed in the Exclusions Section**.

Ambulance Services

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

The following types of Ambulance Services are Covered:

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

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

- Within New Mexico, to the nearest In-network facility where Emergency Healthcare Services and treatment can be rendered, or to an Out-of-network facility if an In-network facility is not reasonably accessible or able to provide required care. 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 Healthcare Services and treatment can be rendered. Such services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- 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 Healthcare Services, as defined above.
    - The presenting symptoms.
    - Whether a Reasonable/Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health.
    - Whether you were advised to seek an Ambulance Service by your Practitioner/Provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this 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.

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 when medically necessary. However, 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.
- 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

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.

Allergy Testing and Treatment

This plan provides coverage for allergy testing and treatment.

Anesthesia

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

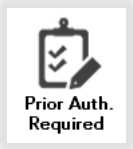
These benefits include coverage for anesthesia and the administration of anesthesia. Anesthesia may be billed separately from other medical services or procedures, and you may incur separate Cost Sharing. Anesthesia may include coverage of hypnotherapy. General anesthesia may be provided where local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

Bariatric Surgery

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

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

Limitations: 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 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 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 the 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.

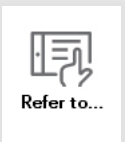
Benefits for Inpatient and in-home Hospice services are Covered if you are terminally ill. Services must be provided by an approved Hospice program during a Hospice benefit period and will not be Covered to the extent that they duplicate other Covered Services available to you. Benefits that are provided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

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. The plan may not authorize more than one additional hospice benefit period.
- You must be a Covered Member throughout your Hospice benefit period.

The following services are Covered:

- Inpatient Hospice care.
- Practitioner/Provider visits by Certified Hospice Practitioner/Providers.
- Home Health Care Services by approved home 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

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

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

Clinical 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 the United States Food and Drug Administration (FDA), whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for the manufacturer, distributor or provider of the drug.

Routine patient care costs 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 recurrence, 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 United States Food and Drug Administration (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, and
    - 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
- 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.

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

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 for HDHP/HSA eligible plans, after the deductible is met.

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

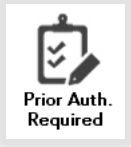
You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/member/health-wellness-information**.

Screening and Counseling Services

Screenings and counseling services will provide coverage for evidence-based services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force for

individuals in certain age groups or based on risk factors. Key screenings include but are not limited to:

- Abdominal aortic aneurism screening for men **aged 65 to 75** who have ever smoked.
- Anxiety in Children and Adolescents: Screening **age 8 to 18**.
- Prediabetes and Type 2 diabetes mellitus screening for adults **age 35 to 70** 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 **age 45-65**. Refer to the Heart Artery Calcification section for more details.
- Falls prevention screening for adults **age 65** or older.
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- Hepatitis B screenings for persons at high risk of infection.
- Hepatitis C screenings for adults **age 18 to 79**.
- Latent tuberculosis screening for high-risk populations.
- Lung cancer screenings for **age 50 to 80** with a history of tobacco.
- Preventive Physical Examinations.
- Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication adults **age 40 to 75** 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 pre-cancerous or cancerous conditions and other health problems including:
    - Fecal occult blood testing (FOBT).
    - Flexible sigmoidoscopy.
    - Colonoscopy, and polyp removal when performed as a screening:
        - Anesthesia services are also at no Cost Share to Covered members when performed as part of Colonoscopy screening.
    - Virtual colonoscopy – requires **Prior Authorization**
    - Double contrast barium enema



- After a colonoscopy, any pathology exam that's required for a biopsy anesthesia a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test.
- 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 **age 18 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** of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.
- Certain prescription drugs for preventive care, the treatment of illness, behavioral health, or Substance Use Disorders will be Covered at No Charge to you, when obtained from a participating pharmacy. See your Plan's Covered drug list for details.

Mammography Services

The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than **age 40** 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.

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 *Formulary* 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) 923-5678**. 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) 923-5678** or **1-800-356-2219**

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 Managed Health Care Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689
Phone: **(505) 827-4601** or **1-855-427-5674**
Fax: **(505) 827-4253**
Email: **mhcb.grievance@osi.nm.gov**
File a 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 our 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 Managed Health Care Bureau
P.O. Box 1689

Santa Fe, NM 87504-1689
Phone: **(505) 827-4601** or **1-855-427-5674**
Fax: **(505) 827-4253**
Email: **mhcb.grievance@osi.nm.gov**
File a 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 U.S. Preventive Services Task Force (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 United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP)

Childhood Preventive Health Services

Childhood Preventive Health Services includes Coverage for Well-Child Care in accordance with the recommendations of the U.S. Preventive Services Task Force (USPSTF).

We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.
You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/member/health-wellness-information**.

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 **age 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 – refer to the flyers 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 old**, this includes (as deemed appropriate by the Member's Practitioner/Provider or as requested by the parents or legal guardian) education information on Alcohol and Substance Use Disorder, STIs, and contraception.
- Preventive benefits, as defined by the Affordable Care Act (ACA) for all recommended preventive services, including services related to pregnancy, preconception, and prenatal care.

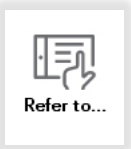
Preventive Health Services for Women

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

You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/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.
- High-risk women **age 30-65** receiving cervical cancer screenings every **five years** with high-risk HPV testing or every **five years** with high-risk HPV testing in combination with cytology (co-testing).

- 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 **age 21 to 65**.
- Chlamydia and gonorrhea screenings for sexually active women **age 25** 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://client.formularynavigator.com/Search.aspx?siteCode=0045707827**.
    - 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 **age 21-65** 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**.

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. It is recommended that Acupuncture be part of a coordinated plan of care approved 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.

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

Chiropractic Services

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

- Presbyterian will not impose a member Cost Share for 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 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 Chiropractic services must be performed by a Chiropractic Provider.
- 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.

Biofeedback

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

COVID-19

As a Presbyterian Health Plan Member, we provide coverage for COVID-19 testing, medical treatment, or vaccination, including boosters. Your coverage is subject to standard plan deductibles or coinsurance for services 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 Healthcare 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, a **Prior Authorization** may be required. Plan benefits for these services include coverage:
  - For Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
  - For Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
  - For Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
  - For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
  - For other procedures for which Hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- 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) treatable by any practitioner of the healing arts such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) are subject to the same conditions, limitations, and may require **Prior Authorization** as they apply to treatment of any other joint in the body.

Diabetes Services

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

Covered Benefits are provided if you have insulin dependent (Type 1) diabetes, non-insulin dependent (Type 2) diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). We will guarantee Coverage for the equipment, appliances, Prescription Drug/Medications, insulin or supplies that meet the U.S. Food and Drug

Administration (FDA) approval, and are the medically accepted standards for diabetes treatment, supplies and education.

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

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 durable medical equipment (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 Healthcare 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
- 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
    - 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 U.S. Food and Drug Administration. 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 healthcare 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) 923-5678** 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) 923-5678**. 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 3**0 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

Limited: 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.

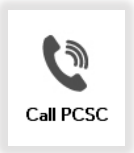
- Insulin pumps when medically necessary, prescribed by a provider
- Insulin Management Systems (Omnipod)
- *Formulary* Continuous Glucose Monitoring (CGM) including system, sensor, and transmitter

- 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
- *Formulary* Test strips for blood glucose monitors
- *Formulary* Lancets and lancet devices
- Visual reading urine ketone strips
- *Formulary* 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) 923-5678** or **1-800-356-2219**. **TTY** users may call **711**. You may also visit **https://www.phs.org/doctors-services/supporting-services/pharmacy-services**.

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

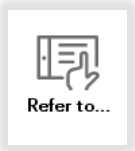
These items require the use of approved brands and must be purchased at an In-network Pharmacy, Preferred vendor or Preferred Durable Medical Equipment (DME) supplier.



Please contact our Presbyterian Customer Service Center from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219**. **TTY** users may call **711**. You may also visit their 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)

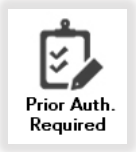
This benefit has one or more exclusions as specified in the Exclusions Section.



Coverage is provided for Diagnostic Services when Medically Necessary and provided under the direction of your Practitioner/Provider. Diagnostic services are tests performed to determine if a member has a medical problem or to determine the status of any existing medical conditions. 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 – requires **Prior Authorization**
- Sleep disorder studies in home or facility. In facility sleep studies require **Prior Authorization**
- Bone density studies
- Clinical laboratory tests – may require **Prior Authorization**
- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiology/X-ray services
- Diagnostic Breast Exams
- Supplemental Breast Exams



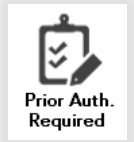
Diagnostic service includes services like mammography, PAP Smears and colonoscopies that are also considered Preventive and are provided to you at no Cost Sharing. Some services like exploratory surgery, angiograms, **imaging**, or follow-up procedures to Preventive services can also be diagnostic, but not Preventive and would apply the appropriate Cost Sharing (Copay, Coinsurance) based on the service.

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

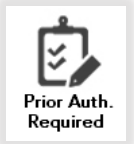
This benefit has one or more exclusions as specified in the Exclusions Section.

Durable Medical Equipment

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



Custom Orthotic Appliances



Custom Orthotic Appliances include braces and other external devices used to correct a body function including clubfoot deformity. Custom Orthotic Appliances must be Medically Necessary and may require **Prior Authorization**.

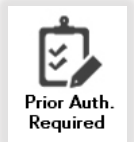
Cost-Sharing requirements are not more restrictive than the Cost-Sharing requirements applicable to this plan's medical and surgical benefits, including those for internal devices.

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

- Foot Orthotics or shoe appliances are not Covered, except for our Members with diabetic neuropathy or other significant neuropathy
- Durable medical equipment for the treatment of active diabetic foot ulcers, including topical oxygen therapy is covered.
- Prefabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for our Members in accordance with nationally recognized guidelines
- Orthotic appliances may be limited to a calendar year maximum
- Covered Custom Orthotic Appliances including:
    - Podiatric appliances for prevention of feet complications associated with diabetes
    - Braces and other external devises used to correct a body function including clubfoot deformity
    - 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**.

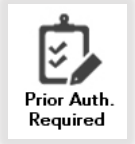


Cost-Sharing requirements are not more restrictive than the Cost-Sharing requirements applicable to this plan's medical and surgical benefits, including those for internal devices.

Examples of Prosthetic Devices include, but are 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 Orthotic Devices



Repair and replacement of Durable Medical Equipment, Prosthetics and 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 **3 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 as, but not limited to, running, biking, swimming and 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 Healthcare Professional requiring Medically Necessary debridement (wound cleaning)

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

Eyeglasses and Contact Lenses (Limited)

The following will only be Covered:

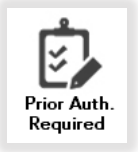
- Contact lenses are Covered for the correction of aphakia (those with no lens in the eye) or keratoconus. This includes the Eye Refraction examination.

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

Hearing Aids

Hearing Aids and the evaluation for the fitting of Hearing Aids are Covered every **36 months** per hearing impaired ear. Coverage is for a Hearing Aid and any related service for the full cost of one Hearing Aid per hearing-impaired ear. This shall include the fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by an audiologist, a hearing aid dispenser or an In-network Practitioner/Provider licensed in New Mexico.

Electroconvulsive Therapy (ECT)



Electroconvulsive Therapy requires **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.

Fertility Services

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

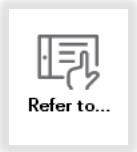
Vasectomies are covered except for under high-deductible individual or group health plans until an insured's deductible has been met. Tubal ligation/sterilization is a covered benefit.

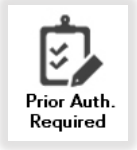
Genetic Inborn Errors of Metabolism Disorders (IEM)

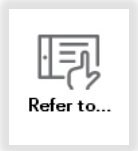
This benefit has one or more exclusions as specified in the Exclusions Section.

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. 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. Special medical foods may be prescribed for other medically necessary conditions. This does not include coverage of nutritional items/food supplements that are available over-the counter and/or without prescription.
- One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is Covered within **12 months** after cataract surgery or when related to Genetic Inborn Error of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.



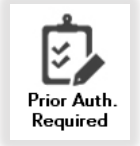




Refer to your *Summary of Benefits and Coverage* for applicable Cost-Sharing amounts (office visit Copayments, Inpatient Hospital, Outpatient facility, Prescription Drug/Medications and other related Deductibles, Coinsurance and/or Copayments).

Genetic/Genomic Testing

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



Gym Membership

As a Presbyterian 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 functional abilities that may not be developing normally. These services are Covered and may require **Prior Authorization**. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Autism Spectrum Disorder

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

- Diagnosis for the presence of Autism Spectrum Disorder when performed during a Well-Child or Well-baby screening 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

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 are placed on covered ABA services.

Coverage for Autism Spectrum Disorder is limited to treatment that is prescribed by the member's treating physician in accordance with a treatment plan. Coverage for autism spectrum disorder may be subject to other general exclusions and limitations of the insurer's plan, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of healthcare services, including the review of medical necessity, case management and other managed healthcare provisions.

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

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

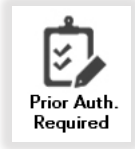
- The diagnosis
- The proposed treatment by types
- The frequency and duration of treatment
- The anticipated outcomes stated as goals
- The frequency with which the treatment plan will be updated
- The signature of the treating physician

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 **ages 45-65** 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 calcium 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 Healthcare Services provided to you when you are confined to the home due to physical illness. Home Health Care Services requires **Prior Authorization** and your Practitioner's/Provider's approved plan of care.

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

Such services may include collection of specimens to be submitted to an approved laboratory facility for analysis. Medical equipment, Prescription Drugs and Medications, laboratory services and supplies deemed Medically Necessary by a Practitioner/Provider for the provision of health services in the home, except Durable Medical Equipment, will be Covered.

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

- 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, physician's office, freestanding (ambulatory) infusion suite, or Outpatient facility.
- These medications include, but are 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.
- Medical Drugs may require a **Prior Authorization**, and some must be obtained through the specialty network.
    - For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our In-network Specialty

network, please see the Presbyterian Pharmacy website at https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739.
    - You may call our Presbyterian Customer Service Center for more information at **(505) 923-5678** or **1-800-356-2219,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Limitation: The plan limits this benefit to **100 day**s per year.

Home/Durable Medical Equipment

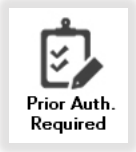
This plan covers equipment that meets the following standards:

- 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 Services, and Eligibility, Enrollment and Termination and Continuation Sections** of this Agreement.

Inpatient Hospital benefits also includes Acute medical detoxification.

Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of The Undersea and Hyperbaric Medical Society (UHMS), or as medically necessary Hyperbaric Oxygen Therapy is **Excluded** for any other condition. Hyperbaric Oxygen Therapy requires **Prior Authorization** 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.

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 *Formulary* 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.

When In-network access to mental health or Substance Use Disorder services are not reasonably available, Presbyterian will provide access to Out-of-network services with no Cost-Sharing obligations.

Mental Health Services

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.

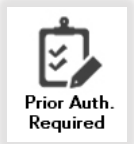
At the members request, Presbyterian may facilitate communication between mental health or Substance Use Disorder services providers and the member's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the insured.

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 provider (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. Some services require **Prior Authorization** except when requesting emergency services.

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 U.S. Food and Drug Administration or 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 Inpatient 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

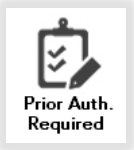
Mental Health Services

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**.

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

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

- Schedule an appointment with a behavioral health provider
- Call your primary care provider (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**.

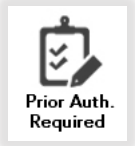
For Out-of-network Services, Members need to contact our Behavioral Health Department in order to obtain **Prior Authorization**, when required. Please refer to the **Prior Authorization** Section.

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 be **Prior Authorized** except when requesting acute care, initial or emergency services. Presbyterian will not use more restrictive limitations on mental health and Substance Use Disorder benefits than on medical or surgical benefits, including visit limitations, utilization review, or **Prior Authorization**.

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

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



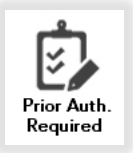
Nonemergency care when traveling outside the U.S.

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

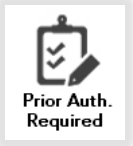


Nutritional supplements that require a prescription to be dispensed are Covered when prescribed by an In-network Practitioner/Provider and when Medically Necessary to replace a specific documented deficiency. **Prior Authorization** is required.

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.

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.

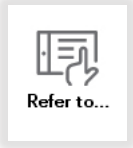
Custom Orthotics

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 but may charge a facility fee. Outpatient Medical Service facility fees are a covered benefit.



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**.

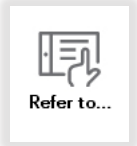
Facility fees are determined by the facility providing the service. Members can inquire from the facility what the charge would be prior to receiving service and they can also receive an estimate for the cost of the service by using Presbyterian's treatment cost estimator tool. If a member

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 Services Benefit Sections**.

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

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



Positron Emissions Tomography (PET) Scans in an Outpatient Setting

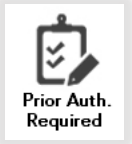
Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that quantifies biochemical processes in living tissue. Positron Emission Tomography (PET) scans in an Outpatient setting require **Prior Authorization**.

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, including primary care services. Practitioner/Provider services include, but are not limited to, periodic examinations and office visits by:

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



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

- Office visits provided by a qualified Practitioner/Provider.
- Virtual Care is provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters. Virtual Care utilizes a nationwide network of Providers.
- Telehealth appointments through video or phone are with a network Provider, including some Presbyterian Medical Group Providers.
- Online visits are an online medical interview followed by a response from a Presbyterian Medical Group Provider.
- Behavioral health services will be provided via telemedicine on the same terms as physical health services in compliance with the telemedicine parity and mental health parity laws.
- Outpatient surgery and Inpatient surgery including necessary anesthesia services. Anesthesia may include hypnotherapy.
- FDA approved contraceptive devices and prescription drugs as described on the drug *Formulary*.
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care. Skilled nursing facility stays are limited to **60 days** per year.
- Coverage for allergy testing and treatment.
- Tubal ligation/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.

Presbyterian will not produce a health benefits plan for sale or pharmacy benefits services for contract without prior disclosure to the Group of the plan or services of the option to contract for pharmaceutical drug Cost-Sharing protections. When calculating a member's Cost-Sharing obligation for covered prescription drugs, Presbyterian shall credit the member for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

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 no cost 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 you 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) 923-5678** or **1-800-356-2219**. **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.

Confidentiality

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

Coverage for Contraception Where a Prescription Is Not Required

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

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

Address: Presbyterian 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 EHB-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 Food and Drug Administration (FDA).
- **Quantity Limits over time** limits quantities to number of units (i.e. tablets, capsules, milliliters, milligrams, doses, etc.) in a defined period of time.

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 Out-of-pocket Maximum 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

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.

- 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.

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.

For more information contact our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call our **TTY** line at **711.**

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

Benefit Limitations

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

You have the option to purchase up to a **90-day** supply of Prescription Drugs/Medications. Under the up to a **90-day** at Retail Pharmacy benefit, Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Drugs can be obtained from an In-network Pharmacy. If you 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:

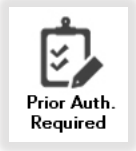
- Applicable Cost-Sharing amount for the prescription drug
- Amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts
- Total amount the pharmacy will be reimbursed 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:

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

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) 923-5678** or **1-800-356-2219**. Hearing impaired users may call **TTY 711**.

Office Administered Specialty Pharmaceuticals (Medical Drugs)

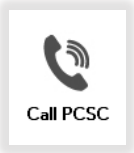
A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or Outpatient facility. Medical Drugs may require a **Prior Authorization,** and some must be obtained through the specialty 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) 923-5678** or **1-800-356-2219,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

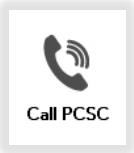
Member Reimbursement

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.

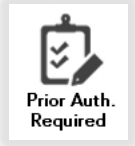
The following information is needed to determine reimbursement amounts. Please submit a *Prescription Drug Reimbursement Form* and attach the itemized cash register receipt and the prescription drug detail (pharmacy pamphlet) along with the following information:

- 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) 923-5678** or **1-800-356-2219,** Monday through Friday from 7 a.m. to 6 p.m.

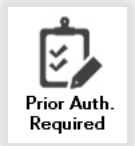
Proton Beam Irradiation



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 and must be medically necessary. Reconstructive Surgery must be prescribed by a Member's Practitioner/Provider and requires **Prior Authorization**. For information regarding Reconstructive Surgery following a Mastectomy and Prophylactic Mastectomy, refer to the **Women's Healthcare Section**.

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.

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.
- Skilled nursing facility stays are limited to **60 days** per plan year.

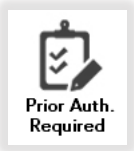
Selected Surgical/Diagnostic Procedures

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
- 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
- Varicose Vein Procedures

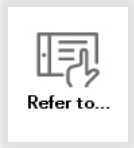
Skilled Nursing Facility Care

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



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

Limitation: Skilled nursing facility stays are limited to **60 days** per plan year.



Refer to the Skilled Nursing benefits on your *Summary of Benefits and Coverage* for your visit limitations.

Telemedicine Services

Presbyterian Health Plan provides coverage for telemedicine services 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

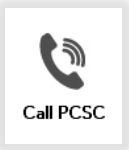
- Virtual Care provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters. Virtual Care utilizes a nationwide network of Providers.
- Telehealth appointments through video or phone are with a network Provider, including Presbyterian Medical Group Providers.
- Online visits are an online medical interview followed by a response from a Presbyterian Medical Group Provider.
- Behavioral health services will be provided via telemedicine on the same terms as physical health services in compliance with the telemedicine parity and mental health parity laws

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 Healthcare Professionals with specific training in managing your Tobacco Cessation Program. The program is described as follows:

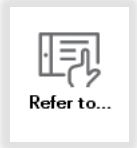
- Individual counseling at an In-network Practitioner's/Provider's office is Covered under the medical benefit. The Primary Care Practitioner or the In-network specialist Copayment applies.
- Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Practitioner/Provider. 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 contact our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**, Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Pharmacotherapy benefit Limitations

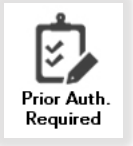
- Prescription Drugs/Medications purchased at an In-network Pharmacy
- Two **90-day** courses of treatment per Contract Year



Refer to 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**.

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

- Deny that coverage solely on the basis of a covered person's physical or mental disability;
- Deny to a covered person with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit policy or plan solely for the purpose of avoiding the requirements of this section;
- Penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a healthcare provider to induce that healthcare provider not to provide an organ transplant or associated care to a covered person with a physical or mental disability; or

- Reduce or limit coverage benefits to a covered person with a physical or mental disability for the associated care related to organ transplantation as determined in consultation with the physician and patient.

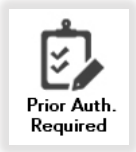
Human Solid Organ transplant benefits are Covered for:

- Kidney
- Liver
- Pancreas
- Intestine
- Heart
- Lung
- Multi-visceral (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**.

Weight Loss Programs



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. See also, benefits described under Bariatric Surgery. This procedure requires **Prior Authorization.**

Women's Healthcare

The following Woman's Healthcare 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**.

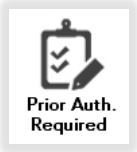
Gynecological care includes:

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

Prenatal

Maternity care benefits include:

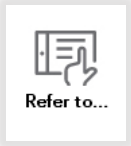
- Prenatal care
- Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between **16 and 20 weeks** of pregnancy, to screen for certain abnormalities in the fetus)
- Visits to an Obstetrician
- Certified Nurse-midwife
- Licensed Midwife
- Medically Necessary 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 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.

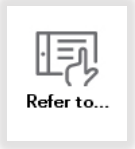
Newborn Care

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

- We must receive the signed and completed enrollment Application for the newborn that was submitted to the employer Group within **31 days** from the date of birth.
- The member's newborn or the newborn of a member's spouse will be covered from the moment of birth if the carrier receives notice that the member has elected coverage for the newborn within specified timeframes in state and federal law.
- If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed enrollment Application within the first **31 days** following the date of birth.
- If the above conditions are not met, we will not enroll the newborn for Coverage until the next Annual Group Enrollment Period.
- Neonatal care is available for the newborn of a Member for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a Cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, it is considered a separate Hospital stay and requires **Prior Authorization**. Refer to 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 or mother Coverage includes transportation, including air Ambulance Services to the nearest available Tertiary facility. Newborn Member benefits also include Coverage for newborn visits in the Hospital by the baby's Practitioner/Provider, circumcision, incubator, and routine Hospital nursery charges.
- A newborn of a Member's Dependent child **cannot** be enrolled unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by the court as the newborn's legal guardian.

Additional Women's Healthcare Benefits

- Mammography and Diagnostic Mammography Coverage.
- Mastectomy, Prophylactic Mastectomy, Prosthetic Devices 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 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**).

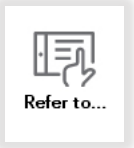
General Limitations

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 Healthcare 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 Healthcare Insurer consistent with such federal, national, and professional practice guidelines, or any service for which the required approval of a government agency has not been granted at the time the service is provided.

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

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

Ambulance Services

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

Autopsies

Autopsy costs for deceased, 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

- Costs of the clinical trial that are customarily paid for by the government, biochemical, pharmaceutical, or medical device industry sources are not Covered

- The cost of a non-FDA approved investigational drug, device, or procedure is not Covered
- The cost of a non-healthcare service 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 trial is 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 is not Covered
- Costs paid for or not charged by the clinical trial providers is not Covered

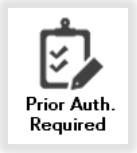
Care for Military Service Connected Disabilities

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
- Long-term, custodial nursing home care for non-terminal condition 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.

Clothing or Other Protective Devices

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

Clinical Preventive Health Services

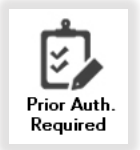
Physical examinations, vaccinations, drugs, and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to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

Immunizations for the purpose of foreign travel are not Covered.

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 are not Covered. **Prior Authorization** is required for any Out-of-network Services and such services must be provided for in the five-county area unless in an urgent or emergent situation as defined by your benefits.

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.

Complementary Therapies

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

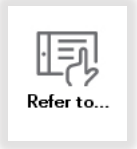
- **Acupuncture** – Except as specified under Complementary Therapies in the Benefits Section.
- **Chiropractic Services** – Except as specified under Complementary Therapies in the Benefits Section.
- **Biofeedback** – Except as specified under Complementary Therapies in the Benefits Section.

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**.

Medically necessary surgery performed to confirm a covered person's gender is not considered cosmetic surgery and will be covered.

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

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

Costs for Extended Warranties and Premiums for Other Insurance Coverage

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

Covered by Other Programs or Laws

This plan does not cover a service, supply, device, or drug if:

- Someone else has the legal obligation to pay for services and without this group health set of benefits, you would not be charged.
- Your benefits do not include care for Military Service Connected Disabilities to which you are legally entitled and for which facilities are reasonably available to the members.
- 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.

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

- Routine, preventive, and major adult dental care is not covered
- 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.

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

Durable Medical Equipment

Upgraded or deluxe Durable Medical Equipment is not Covered.

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

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

Repair and Replacement

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

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

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

Orthotic Appliances

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

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

Prosthetic Devices

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

Surgical Dressing

Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, adhesive bandages, gauze (such as 4 by 4's), 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 is 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, Procedures, or Devices

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

Experimental or Investigational medical, surgical, diagnostic genetic testing, other healthcare procedures or treatments, including drugs. As used in this 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 BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder if that person has a known family history or classic symptoms of a disorder. Genetic testing is not covered when the test is performed primarily for the medical management of other family members. Additional expenses for banking of genetic material are not covered.

Genetic Inborn Errors of Metabolism Coverage

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

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

Hair loss (or baldness)

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

Home Health Care Services/Home Intravenous Services and Supplies

Private duty nursing is not Covered.

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

Hospital Services

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 unless for treatment of the underline cause of infertility to comply with 13.10.21.8(M)(7) NMAC.

Infertility services listed below are not Covered

- Prescription Drugs Oral and Injectable for the treatment of infertility when provided by a practitioner/provider are not Covered
- 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

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 or domestic partner) 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 or domestic partner) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of their practice.
- Electronic mail (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.

Out-of-State Surcharges

Out-of-state surcharges are not Covered

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 or domestic partner) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of their practice.
- Electronic mail (email) by a Practitioner/Provider for which the practitioner/provider charges is not Covered
- 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.

- 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 Medical Necessity has not been established are not Covered.
- Prescription Drugs/Medications that are identified by Drug Efficacy Study Implementation (DESI) as Less than Effective (LTE) DESI drugs are not Covered.
- Replacement Prescription Drugs/Medications resulting from loss, theft, or destruction are not Covered.
- Disposable medical supplies, except when provided in a Hospital or a Practitioner's/Provider's office or by a home health professional, are not Covered.
- Prescription Drugs/Medications used in conjunction with In-vitro fertilization and artificial insemination are not Covered.
- Oral or injectable medications used to promote pregnancy are not Covered.

- Over-the-counter (OTC) medications and drugs are not Covered. Refer to our *Formulary* for a list of Covered Over-the-counter (OTC) medications as determined by our Pharmacy and Therapeutics Committee.
- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are not Covered.
- Prescription Drugs/Medications for the purpose of weight reduction or control, except for Medically Necessary treatment for morbid obesity, are not Covered.
- Prescription Drugs/Medications used for cosmetic purposes are not Covered.
- Nutritional supplements as prescribed by the attending Practitioner/Provider or as sole source of nutrition are not Covered.
    - Infant formula is not Covered under any circumstance.
    - This does not apply to the nutritional supplements required under Home Health Services.
- Compounded Prescription Drugs/Medications are not Covered.
    - Bulk powders are not Covered.
    - Compounding kits are not Covered.
- Brand name drugs dispensed when a generic equivalent is available will not count towards Deductible or Out-of-pocket Maximums unless Medical Necessity has been met.
- Herbal or alternative medicine and holistic supplements are not Covered.
- Vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, or functional capacity examinations related to employment are not Covered.
- Immunizations for the purpose of foreign travel, flight and or passports are not Covered.
- Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy including “all-natural” pills, creams, lotions and gels and non-FDA approved hormone pellets are Not Covered.
- Local Delivery of Antimicrobial Agents (LDAA) used for Periodontal Procedures are Not Covered.
- Convenience packaging unless convenience packaging is medically necessary for drug adherence due to a disability.

Radiation

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

Reconstructive Surgery for Cosmetic Purposes

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

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

Rehabilitation and Therapy

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

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

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

Speech Therapy services listed below are not Covered:

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

Thermography

Thermography Services are 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 Over-the-counter (OTC) medication on our *Formulary*
- Acupuncture for Tobacco Cessation Counseling is 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.

Weight loss Programs

- Treatments and medications for the purpose of weight reduction or control, except for medically necessary treatment of morbid obesity and obesity

- Exercise equipment, videos, personal trainers, club members and weight reduction programs

Women's Healthcare

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

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

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

Work-related Illnesses or Injuries

This plan does not cover services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. Work-related illnesses or injuries are not Covered, even if:

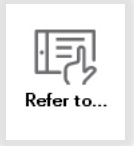
- You fail to file a claim within the filing period allowed by the applicable law
- You obtain care not authorized by Workers' Compensation Insurance
- You fail to comply with any other provisions of the law

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. Notice given by or on behalf of the insured or the beneficiary to Presbyterian at the principal location, or to any authorized agent, with information sufficient to identify the insured, will be deemed notice to the plan.

Claim Forms

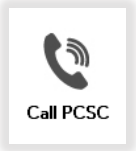
You may call or write to us to notify us of a claim. Presbyterian Health Plan, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within **15 days** after the giving of such notice the Member 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. You may access our website, **https://www.phs.org/health-plans** to obtain a claim form.

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

possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required

In-network Practitioners/Providers

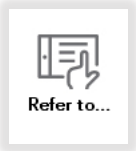
We reimburse In-network Practitioners/Providers for Covered services provided to you. You should not be required to pay sums to any In-network Practitioner/Provider, except for the required Cost-Sharing amount. You will be responsible for the payment of fees charged for missed appointments or appointments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



If you are asked by an In-network Practitioner/Provider to make any payments in addition to the Cost-Sharing amount specified in this Agreement, you should consult our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**, 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 Healthcare Services described in the **Accidental Injury (Trauma) / Urgent Care / Emergency Health Services / Observation Services 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 Healthcare Services rendered to a Member while traveling shall be Covered as specified in the **Accidental Injury (Trauma) / Urgent Care/Emergency Health Services/Observation Services 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 Healthcare Services for which claim is made.

If you need a claim form or have questions regarding a charge made by your Practitioner/Provider, please contact our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**, 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 Healthcare Services and Urgent Care services received outside the United States. These services are Covered as explained in the **Benefits Section**. You are responsible for ensuring that claims sent to us, at the address cited above, are appropriately translated and that the monetary exchange rate effective on the date(s) you received medical care is clearly identified when submitting claims for services received outside the United States.

Presbyterian cannot reimburse foreign Practitioners/Providers. You should then submit the claim, or a summary of the medical services rendered, in addition to Proof of Payment. Proof of payment includes a copy of 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**

Indemnity

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of

payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

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

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

Effects of Other Coverage

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

Coordination of Benefits

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

Coordination of Benefits (COB) applies to this 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:

- Employee/Dependent Rule:
    - The plan, which covers you as an employee, 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.
- Active/Inactive Employee:
    - The plan, which covers you as an active employee (or Dependent of an active employee), pays first.
    - The plan, which covers you as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.
- Longer/Shorter Employment:

    - In the case where you are the Subscriber under more than one group health insurance Agreement, then the plan that has Covered you for a longer period of time will pay first. A change of insurance carrier by the group employer does not constitute the start of a new plan.
- If you are covered under a motor vehicle or homeowner's insurance 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 provide 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.

HSA Note: If you are entitled to and/or enrolled in Medicare, then you may not be eligible to contribute to a Health Savings Account (HSA). Please contact your HSA administrator or financial institution for further information.

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.

HSA Note: If you are entitled to and/or enrolled in Medicare, then you may not be eligible to contribute to a Health Savings Account (HSA). Please contact your HSA administrator or financial institution for further information.

Subrogation (Recovering Healthcare 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.

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.

HSA Note: Generally, an individual is ineligible for a Health Savings Account (HSA) if the individual, while Covered under a qualified HDHP, is also Covered under another health plan (whether as an individual, spouse, or Dependent) that is not a qualified HDHP. However, certain other kinds of health coverage may be maintained (by an individual) without losing eligibility for an HSA. Please contact your HSA administrator or financial institution for further information.

An individual does not fail to be eligible to contribute to an HSA merely because, in addition to a qualified HDHP, the individual has Coverage for any benefit provided by permitted insurance. Permitted insurance is insurance under which substantially all of the coverage provided relates to liabilities incurred under Workers' Compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., automobile insurance), insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization.

Please contact your HSA administrator or financial institution for further information on eligibility requirements.

Summary of Health Insurance Grievance Procedures

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 pre-authorization 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:

- Delay would jeopardize your life or health
- Delay would jeopardize your ability to regain maximum function
- The physician with knowledge of your medical condition **reasonably** requests an expedited decision
- 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
- 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. An insurance company is not allowed to require you to obtain **Prior Authorization** for emergency care.

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

The insurance company is required to notify you on 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 appealed?

You may request appeals 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 healthcare services; claims payment, handling, or reimbursement for healthcare 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) 923-5678** or **1-800-356-2219**
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.
- 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.

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.

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.

Hint: 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 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 Healthcare Services without your consent/authorization. Such review programs include, but are not limited to, the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and the Office of the Superintendent of Insurance (OSI).

Confidentiality of Protected Health Information/Medical Records

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

What is PHI?

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

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

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

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

Access to PHI

All confidential documents are kept in a physically secure location with access limited to authorized Plan personnel only. You (or your legal guardian/Personal Representative) have the right, with certain exceptions, to request access to inspect and obtain a copy of your PHI. 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:

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

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

Routine Uses and Disclosures of PHI

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

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

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

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

Consents/Authorizations

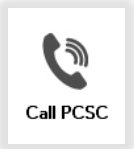
Although consent from you (or your legal guardian/Personal Representative) is not required to use or disclose PHI for certain purposes specified in the law, a Practitioner/Provider shall request that you (or your legal guardian/Personal Representative) sign a consent form permitting disclosure of medical records (to the extent permitted by law) to us at the time of your first visit to the Practitioner/Provider.

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

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

We will not 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 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) 923-5678** or **1-800-356-2219**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**. Authorization Forms will be kept in your medical record or enrollment file.

Members Who Are Unable to Give Consent/Authorization

Sometimes courts or doctors decide that certain people are unable to understand enough to make decisions for themselves. Usually, a person with legal authority to make healthcare decisions for a child or other person (for example, a parent or legal guardian) can exercise the health information rights described herein for the child or other person, but not always. Unless

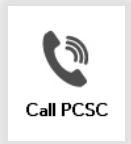
otherwise required or permitted by law, when we need an Authorization Form signed for a person who can't make healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

Right to Request Amendments (Changes) to PHI

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

Process for Members to Request an Accounting of Disclosures of PHI

You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center by calling Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you to others without authorization from you.



Restriction of PHI Use or Disclosures

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

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

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

Use of Measurement Data

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

Internal Protection of Oral, Written and Electronic PHI Across PHP

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

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

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

Website Internet Information

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

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

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

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

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

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

If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219**. 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.

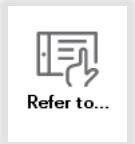
How You Can Enroll as a Member

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.

Eligible Subscribers

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

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



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.

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

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

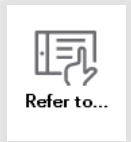
Eligible Dependents

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

- Your legally married Spouse (of the Subscriber), as defined by state law
    - Physically live or work in the five-county area, our Service Area
- Your Domestic Partner as defined by and if specified as eligible by your Employer Group
- Your Dependent child who is:
    - Under **age 26**; 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 for Covered Benefits under this Contract shall terminate at the end of the month of the child's **26th birthday** unless the Dependent child is totally and permanently disabled.



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.

HSA Note: For the purposes of establishing a qualified Health Savings Account, you are reminded that an eligible individual means, with respect to any month, any individual who:

- Covered under a Qualified High Deductible Health Plan (HDHP)
- Is not also Covered by any other health plan that is not a qualified HDHP (with certain exceptions for plans provider certain limited types of Coverage)
- Is not entitled to benefits under Medicare
- May not be claimed as a Dependent on another person's tax return

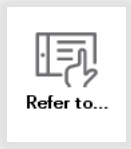
Please see the Effects of Other Coverage section for further eligibility information or contact your HSA administrator or financial institution.

Residence of a Dependent Child

Dependent Student

Dependent Students attending school within the five-county area may either receive care through their Primary Care Physician or at the Student Health Center. A **Prior Authorization** form is not needed prior to receiving care from the Student Health Center.

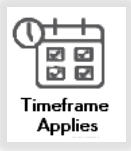
Dependent Students attending school may also receive care at the Student Health Center without **Prior Authorization** from us. Services provided outside of the Student Health Center are limited to Medically Necessary services for the initial care or treatment of Emergency Healthcare Services or an Urgent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



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

Total and Permanent Disability of an Enrolled Dependent Child

When an enrolled Dependent child reaches 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 mental disability or physical disability and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish us with proof of such disability, incapacity and dependence within **31 days** of the Dependent child's attainment of **age 26**. Your provider is



responsible for submitting documentation of the disability and it will be reviewed by the Presbyterian medical team. No specific form is required, only whatever the provider deems necessary to provide evidence of the disability. As your dependent child approaches **age 26**, you will be notified that they will age off the plan unless evidence of a disability is furnished by your provider. If we approve continued Coverage, we may request proof of the disability on each birthday after the two-year period following the attainment of **age 26**.

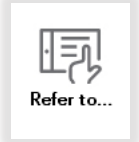
Medicare-Eligible Members (TEFRA)

Shortly before you turn **age 65** or qualify for Medicare Benefits, you are responsible for contacting the local Social Security office to establish your Medicare eligibility. You should then contact your Group's benefits administrator to discuss your Coverage choices.

- If Medicare is Secondary (TEFRA)
    - If your Group is subject to the Tax Equity & Fiscal Responsibility Act (TEFRA) and if you are actively at work at **age 65** and older, you may continue the Coverage provided under this Agreement until you retire. In that case, this Coverage will be primary over Medicare benefits. There may be other circumstances that allow you to retain this Coverage when you are eligible for Medicare. You should contact the Social Security Administration for more information.
- If Medicare is Primary
    - If you are eligible for Medicare and you select Medicare as your primary health plan, the Coverage under this Plan is not available to you.
- If your Group is not subject to the federal law (TEFRA) and is not required to offer Group Coverage that you may select to be primary over Medicare when you are actively working at **age 65** and beyond the following may apply:
    - Active employees and their dependents who are enrolled in conventional coverage may also enroll in our Group healthcare Plans.
    - For Groups with two to19 total employees, Medicare Parts A&B are considered the Primary insurance carrier, and we would be the secondary carrier.
- If your Group does not offer Coverage secondary to Medicare, please refer to **Continuation of Coverage** later in this Section for more Coverage options.

Subscribers and Dependents Who May NOT Enroll

- A Subscriber's grandchild is not eligible for Coverage unless the grandchild meets the eligibility criteria for a Dependent.
- A child born of a Member, when the Member is acting as a surrogate parent, is not eligible for Coverage.



- A Subscriber and/or Dependent is not eligible to enroll for Coverage if either Subscriber or Dependent has had a prior Contract or 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 a completed Application, together with any required Prepayment, at the appropriate times as discussed below.

When Your Employer signs our Group Letter of Agreement (GLA) – The Initial Group Enrollment Period

A Subscriber and the eligible Dependents may enroll during the Initial Group Enrollment Period, after the Employer and our Company execute the Group Letter of Agreement (GLA). If you, as the Subscriber, were hired as a full-time employee and your employer is not waiving the initial waiting period, you must meet the Employer's waiting period requirements.

You (as the Subscriber) and your eligible Dependents must complete and sign an Application and submit it with any required Prepayment to the Group. We must receive the signed and completed Application, along with any required Prepayment, within **31 days** of the initial effective date of the Plan.

The Annual Group Enrollment Period

Each year there will be an Annual Group Enrollment Period. During the Annual Group Enrollment Period, Subscribers and their eligible Dependents who were previously eligible but **have not previously enrolled** in our Coverage may enroll. The effective date of Coverage for new Members who enroll during the Annual Group Enrollment Period shall be 12:01 a.m. on the date of the Contract Year for which they enroll. We must receive the signed and completed Application and any required Prepayment within **31 days** of the initial effective date of the Plan.

Newly Hired Employees During the Year

If you are hired by the Group after an Annual Group Enrollment Period, you must enroll, along with eligible Dependents, within **31 days** after becoming eligible. The effective time and date of Coverage will be 12:01 a.m. on the first of the month following completion of the Group's eligibility requirements and submission of the completed and signed Application. If you do not enroll within the **31-day period**, the earliest time you and your eligible Dependents may enroll is the next occurring Annual Group Enrollment Period except as specifically described in the **Special Enrollment Section**.

Family Status or Employment Status Changes During the Year

During the Contract Year when you are currently enrolled as a Subscriber, you may make certain changes to your benefit election due to a change in family or employment status. We will require evidence of a change in family or employment status in order to change your benefit election. You must complete and sign an Application and submit it with any additional Prepayment amount, within **31 days** of the date of the change in family or employment status. Terminating Coverage for a Dependent from your benefit plan Coverage is not an event that allows you to change your benefit Plan.

We recognize the following family status changes as a reason for adding or removing Dependents:

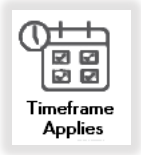
- Marriage
  - Your new Spouse (and any children of the Spouse eligible for Coverage under this Section) is eligible to be enrolled as a Dependent. You must complete and sign an Application and submit it, along with any required Prepayment, to your Employer Group within **31 days** from the date of marriage.

- Divorce or legal separation
  - You must notify us within **31 days** of the date of divorce or legal separation of the change in Dependent Coverage and submit any Prepayment amount.
  - If a terminated dependent requests to move to a separate policy and keep coverage, Coverage will be effective as of the first day of the month following the date we receive the notification of divorce or legal separation
- Birth of a child
  - Your newborn or the newborn of your Spouse will be Covered from the moment of birth when enrolled as follows:
    - We must receive the signed and completed Application that was submitted to the Employer Group within **31 days** from the date of birth.
    - If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed Application within the first **31 days** following the date of birth.

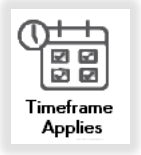
  - If the above two conditions are not met, we will not enroll the newborn for Coverage until the next following Annual Group Enrollment Period. Please refer to the **Benefits Section, Prior Authorization Section, Limitations Section and Exclusions Section** to fully understand the benefits and requirements for Maternity and newborn Coverage.
- Adoption of a child
  - A child under **age 18** who is placed in your home for the purposes of adoption and for whom you have commenced adoption proceedings is eligible to be enrolled as a Dependent.

- The child will be Covered from the date of placement for the purpose of adoption when we receive the signed and completed Application that was submitted to the Group and any applicable Prepayment made within **31 days** the date of placement.
- The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child.
- Such child shall continue to be eligible for Coverage unless placement is disrupted prior to legal adoption. The legal obligation terminates when placement terminates or is disrupted.

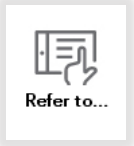
- Legal Guardianship
  - If you or your Spouse becomes the legal guardian for any child pursuant to court order, the child is eligible to be enrolled as a Dependent. You must submit a completed, signed Application and any applicable Prepayment within **31 days** of the court and/or qualified administrative order granting guardianship.
  - The Dependent child will become a Member on the first day of the month following the date the order is filed with the clerk of the court. The Dependent child will continue to be eligible until such time as you or your Spouse are no longer the legal guardian for such child.



- Court ordered or qualified administrative ordered eligible Dependent Coverage
  - If you are required by a court or administrative order to provide Coverage for an eligible Dependent child, the Dependent child may be enrolled. You must submit a completed and signed Application and any applicable Prepayment within **31 days** of the court order. The Coverage for the eligible Dependent child will become effective on the date in accordance with the court or administrative order. If the court order does not stipulate an effective date, the Dependent child will become Covered effective the first day of the month following the date the order was filed as public record with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent child will be the first day of the month following the Employer's receipt of the request.
  - When a Subscriber, who is not enrolled in our Coverage, has been ordered by a court of law or by a qualified administrative order to provide healthcare Coverage for a Dependent child, the child is eligible to be enrolled as a Dependent provided the Subscriber has met the Group's waiting period requirements and the signed Application together with any required Prepayment is submitted within **31 days** from the date on which the Group receives the court and/or qualified administrative order. The Dependent child will become a Member on the day stipulated by the court order.
  - If the Subscriber, who is not enrolled in our Coverage, has not met the waiting period and other eligibility requirements, the Subscriber may not enroll and may



not enroll the Dependent child until the date that eligibility requirements haves been met. The Subscriber must submit the Application and any Prepayment within **31 days** from the eligibility date. The Dependent will become a Member on the date of the Application.
    - **Note:** Only the eligible court-ordered Dependent(s) will be allowed to enroll as a result of the court and/or qualified administrative order. Other Dependents who are not enrolled may not enroll at this time.
- The last day of the month in which your Dependent child turns **age 26** (when Dependent Coverage will terminate unless the Dependent child is as described in the **Totally and Permanently Disabled Dependent Child in this Section**)
- The death of your Spouse or Dependent child
- Disqualification or requalification of your Dependent



We recognize the following changes in Employment Status as a reason for making a change in your benefit election:

- A change in your (Subscriber) Spouse's employment such as loss of job or a new job that provides Dependent care assistance or other healthcare Coverage. Annual Group Enrollment for a Spouse's plan is not an employment status change.
- Unpaid leave of absence for the Subscriber or Dependent Spouse.
- Significant change in the cost of a Spouse's current plan (**50%** or greater).
- Employment transfer that results in a change of residence.

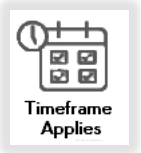
Any change in your Covered Benefit election that you apply for because of a family status or employment status change will become effective on the first day of the month following the date of the status change if you have met the waiting period and other employer Group eligibility requirements. The only exceptions would be the birth and adoption of a child, or court-ordered Coverage, where the change in Coverage would be effective as of the date of birth or placement for adoption and a court-ordered change if the court specifies an effective date.

Special Enrollment for Active Employees and Their Dependents

If you, as a Subscriber, failed to enroll in our Coverage during a previous Annual Group Enrollment Period or within **31 days** after meeting your Employer's waiting period and you became originally eligible, you may enroll during the year due to a Special Enrollment qualifying event.

There are three Special Enrollment qualifying events that will allow you to enroll other than at the Annual Enrollment Period. They are as follows:

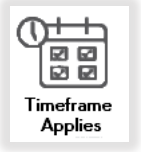
- Change in family status by acquiring a new Dependent(s)
- Loss of other prior Coverage
- Loss of Medicaid/CHIP eligibility



You must apply within **31 days** from the date of a Special Enrollment qualifying event, or within **60 days** from the loss of Medicaid/CHIP eligibility. If you do not request Special Enrollment within the required period specified, you will not be eligible to enroll until the next Annual Enrollment Period.

Special Enrollment – Change in Family Status

If you (Subscriber) are eligible and not enrolled and if you acquire a new Dependent due to marriage, the birth of your natural child or adoption of a child, you and your eligible Dependents may apply for Coverage under the Special Enrollment qualifying event. You must complete, sign and submit an Application, along with required Prepayment, within **31 days** of the marriage, birth or placement for adoption. If you fail to submit an Application within **31 days** of the change in family status, special enrollment is not available.



In the case of marriage, you and your Spouse and any Dependent children acquired because of the marriage may enroll.

In the case of a newborn or adopted child, you, your Spouse, and the newborn or adopted child who triggered the event may enroll. The other siblings who are not enrolled may not enroll until the next Annual Group Enrollment Period.

Effective date of the Family Special Enrollment:

- In the case of marriage, the first day of the first calendar month following the date of the marriage, provided that we receive the completed Application and any required Prepayment within **31 days** of the date of marriage.
- In the case of a Dependent's birth, the date of such birth provided that we receive the completed Application and any required Prepayment within **31 days** of the date of birth.
- In the case of adoption or placement for adoption, the date of such adoption or placement for adoption provided that we receive the completed Application and any required Prepayment within **31 days** of the date of adoption.

Special Enrollment – Loss of Coverage

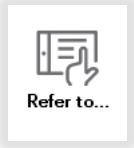
If you (an eligible Subscriber) and/or your eligible Dependent initially declined to enroll in our Coverage because you or your Dependent had other medical coverage and later involuntarily lost the other coverage, the eligible person may enroll as a Subscriber or as a Dependent after the initial eligibility period if the person loses coverage under all of the following circumstances:

- The person was covered under a Group Health Benefits Plan or had individual health insurance coverage at the time the person was initially eligible to enroll.

- At the time, the employee (Subscriber) of the Group was first eligible to enroll, the employee stated, that the employee and/or eligible Dependents were not enrolling because of such other coverage. The employer may require this in writing.
- The person's coverage under the other plan or insurance:
    - Was under a Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 continuation provision and the coverage under that provision was exhausted (and not voluntarily terminated).
    - Was not under a COBRA continuation period and either the coverage was terminated as a result of loss of eligibility or employer contributions toward the coverage were terminated.

You must submit a signed Application with any required Prepayment within **31 days** of the date coverage was terminated either under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, or the date the other coverage (or the other employer's contribution toward Coverage) was terminated.

If the Subscriber and/or Dependent does not enroll during the **31-day** Special Enrollment period, enrollment in our Coverage can occur only during a subsequent Annual Group Enrollment Period.



There are no Special Enrollment periods for you or your Dependents who apply for Continuation, Conversion Coverage or Extension of Benefits. You must apply for and enroll in the Coverage within the time limit required for each Coverage. Refer to **each of these Sections** for information on each Coverage.

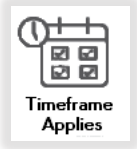
Other Special Enrollment Periods

- **Dependent eligibility for special enrollment periods:** A qualified individual's dependent because of a relationship to a qualified individual enrollee.
- **Special enrollment period for foster placement:** Placement of a foster child is a triggering event for a special enrollment period.
- **Special enrollment period coverage effective dates:** Presbyterian is required to ensure coverage effective dates for special enrollments due to birth, adoption and foster care placement on the date of the triggering event. In cases of special enrollments due to marriage or loss of minimum essential coverage, the Plan must ensure coverage effectuation on the first day of the following month. Plans are otherwise required to ensure that coverage obtained during a special enrollment period is effective on an appropriate date based on the circumstances of the special enrollment period.
- **Special enrollment period for exceptional circumstances:** Presbyterian may allow special enrollment periods for exceptional circumstances.

CHIPRA Special Enrollment Period and Qualifying Event (Children's Health Insurance Program Reauthorization Act)

In accordance with the Children's Health Insurance Program (CHIP) provisions as currently defined under federal law, you and/or your eligible Dependents who are not currently enrolled in our Coverage, may enroll in our Plan. There are two circumstances when this CHIPRA Special Enrollment Period may apply.

- Loss of Medicaid/CHIP Eligibility
    - If you, as an eligible Subscriber, chose not to enroll in our Coverage for yourself and/or Dependent(s) during a previous enrollment period because you and/or your Dependent(s) were covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan, the person who loses Medicaid/CHIP eligibility may enroll in our Coverage. If you, as an eligible Subscriber, are not enrolled for Coverage, you must enroll in our Coverage at the same time as your Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of the date Medicaid or CHIP coverage terminated.



    - You must submit a completed, signed Application within **60 days** of the loss of Medicaid or CHIP coverage. We will require documentation from the State supporting the fact that the person who had the Medicaid/CHIP Coverage lost the Coverage voluntarily. Coverage will start no later than the first day of the month after we receive your Application and any required Prepayment.
    - If you, as Subscriber, lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and your Dependents, including your Spouse. If your Dependent lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and that Dependent (not to other Dependents).

Full, Accurate and Complete Information

You, as a Subscriber, must fully and accurately complete and sign an Application for Coverage as required. False or fraudulent statements or intentional misrepresentations of material fact provided in an Application may result in the Termination of all Coverage for you and your Dependents.

A retroactive Termination of Coverage or rescissions (back to the initial date of enrollment) for fraud or intentional misrepresentation of material fact, except for those attributable to failure to pay prepayments, premiums or contributions may occur. This rule does not apply to prospective Termination of Coverage.

We will provide at least **30 days** advance written notice to each participant who would be affected prior to rescinding coverage.

Change in Address, Family Status and Employment

Changes in your Dependents, marital status, employment or address may affect your Coverage under this Agreement. Please notify your Employer Group's human resources office and ask that they notify us of all changes. You may notify us directly by calling our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**, Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Or visit our website at **www.phs.org**.

Termination of Coverage

The Employer Group Letter of Agreement (GLA) shall be canceled and shall terminate in the event any one of the following conditions occurs:

- **Termination of the Employer Group For Nonpayment:**
  - In the event any Premium, including a Prepayment and any applicable finance charge or charges, is not paid to us when it is due from the Group, we shall notify and mail a Notice of Cancelation to the plan Enrollee within **30 days**. The Group shall then immediately forward to each Subscriber, by first-class mail at their current address, a legible copy of such notice. Termination of this Agreement shall not become effective sooner than **30 days** after the date the notice is hand delivered or mailed to each Subscriber.
  - If we receive payment of the Premium (including any Prepayment and all other applicable amounts and charges) within **15 days** of the issuance of the Notice of Cancelation, it shall be sufficient to prevent cancelation and termination under this paragraph. If we do not receive payment of such charge within this **15-day period**, we may, at our option, either:
    - Require that a new Application for Coverage be submitted, notifying the Group of the conditions under which a new Contract will be issued, or the original Application reinstated; or
    - Elect to abide by this cancelation by returning to the Group, within **20 business days** after receipt, any Prepayment for Coverage for periods after the effective date of cancelation.
  - 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 Group or from the Subscriber any and all payments for Covered Benefits made on behalf of any Subscriber or the Subscriber's Dependent(s) after the last date of the period for which Prepayment was received.
- **Voluntary Termination by the Employer Group of the Group Letter of Agreement (GLA)**
  - Voluntary Termination of Coverage by the Group is governed by the terms of the GLA. Such termination shall only be effective as of the last day of the month.
- **Our Termination of your Employer Group**

- Our termination of the Group is governed by the terms of the GLA and is in accordance with federal and state laws. Our termination or cancelation of the Group shall automatically terminate this Agreement. Upon our cancelation or termination of our Contract with the Group, the Group shall promptly mail a legible copy of the Notice of Cancelation to each Subscriber at the Subscriber's current address and shall promptly provide us with proof of such mailing and the date thereof.
- Such cancelation shall become effective no sooner than **30 days** after the date the Group mails the notice to Subscribers. The notice requirement in this paragraph does not apply to our refusal to renew any GLA that does not contain an automatic renewal provision.

- **Termination of your Group Subscriber Agreement**
  - 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.
  - 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 yourself or any of your Dependents, provided we send written notice to you (the Subscriber) at least **30 days** in advance of such termination. In such case we, at our sole discretion, may terminate Coverage for you and all of your Dependents, and may make such termination effective retroactively as of the date of enrollment. You shall be responsible for payment for all Healthcare Services rendered hereunder as of the effective date of such termination and shall reimburse us for all such Healthcare Benefit payments that we made on your behalf or on behalf of any of your Dependents.

  - Military Service
    - Coverage for you (Subscriber) and your eligible Dependents will terminate at the end of the month during which you entered into active military duty (except for temporary duty of **30 days** or less).
  - At the end of the Contract month in which you (the Subscriber) cease to physically live within the five-county area or work for an employer headquartered in the five-county area, our Service Area. Coverage for all Dependents will terminate on the same date as your (the Subscriber's) coverage
  - At the end of the Contract month in which you cease to be eligible as a Subscriber or Dependent.

- On the date that adoption placement for the child originally placed for adoption, is disrupted prior to legal adoption, and is removed from placement.
- As of the date on which you permit the use of our Identification Card by any other person, we may, at our discretion, terminate Coverage for you and for all Members of your family. We must send written notice to you (Subscriber) at least **30 days** in advance of such termination.

In the event that premiums owed to us has remained unpaid through the grace period allowed for the payment, Presbyterian will be liable for valid claims for Covered losses prior to the grace period except that Presbyterian will be entitled to the premium, due for coverage provided during the grace period. As required by state regulation enforced by New Mexico Division of Insurance, Members Covered under our contract with any employer group must be notified a minimum of **30 days** prior to loss of coverage. If payment in full is not received by the deadline, Presbyterian will notify your Covered employees, adhering to the **30-day** notification requirement, and you will be responsible for an additional month of premiums. Presbyterian will not recognize claims incurred after the end of the grace period if premiums remain unpaid.

If you or any of your Dependents are terminated for Good Cause, as defined in the **Glossary of Terms** section, then you or any of your Dependents are not eligible for COBRA continuation or Individual Conversion.

We will not terminate Coverage under this Agreement for any Member based solely upon the Member's health status, requirements for Healthcare Service, race, gender, age, sexual orientation, or for refusal to follow a prescribed course of treatment. If you or your Covered Dependents believe that Coverage was terminated due to health status or healthcare requirements, you may Appeal the cancelation to the Superintendent of Insurance, at:

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

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 (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

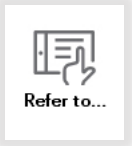
Continuation of Coverage of Your Group Plan

If your Coverage would otherwise terminate because of a loss of eligibility as a Subscriber or Dependent, you may be entitled to continue your Coverage under one of the following options:

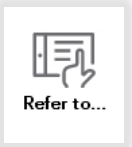
- **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985**
  - Most Employer Groups with **20** or more employees are required to offer continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.
  - If you lose eligibility for Coverage and if you are entitled to COBRA Coverage, you may continue your Coverage as a Member of the Employer Group under this Agreement and in accordance with the GLA for the period of time allowed under COBRA unless and until:
    - You terminate your Coverage.
    - Your Coverage under this Agreement is terminated for Good Cause.
    - You fail to make a timely election for COBRA Coverage.
    - You fail to make timely payments for your COBRA Coverage.
    - You become Covered under another Group Healthcare Plan.
    - You become entitled to Medicare benefits.
      - Members have the choice of whether to enroll in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease (ESRD).
  - Your Group's benefit administrator will provide you with information about your eligibility for COBRA. If you are eligible, you (the Subscriber) or your eligible Dependent must elect COBRA Coverage within **60 days** of the date you lose eligibility for Coverage under this Agreement. Your COBRA Coverage will be effective only if we receive your COBRA Application within **60 days** after the date your Group Coverage under this Agreement terminates.

- If you or your eligible Dependent elects COBRA Coverage and submits your Application, you will have **45 days** from the date of the election to pay the initial Prepayment due. All subsequent Prepayments will be paid on a monthly basis. There is a **30-day** grace period to pay Prepayments. If the Prepayment is not paid before the expiration of the grace period, COBRA continuation benefits will end.
- Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for COBRA continuation.

- **State Continuation of Group Coverage**
  - Employer groups with less than **20** active employees (or otherwise not required to offer COBRA continuation) may provide continuation of non-COBRA Coverage.
  - You, on behalf of yourself and your Dependent(s), upon termination of employment with the Employer Group, have the right to continue your Group Coverage for six months under state law. At the end of the six months, you may convert your Coverage to the individual conversion option that we offer, in accordance with the **non-Group Coverage Section**.



  - An enrolled Dependent, upon loss of eligibility for Coverage under this Agreement (following the continuation of Group Coverage for six months under state law), may have the option of converting the Group Coverage to the individual conversion option we offer. The circumstances and conditions under which conversion is allowed are specified in the **non-Group Coverage Section**.
  - Coverage under this State Continuation option will terminate prior to the end of the **six-month** period of Coverage in the event:
    - You terminate your Coverage.
    - Your Coverage under this Agreement is terminated for Good Cause.
    - You fail to make a timely election for continuation Coverage.
    - You fail to make timely payments for your continuation Coverage.
    - You become Covered under another Group health plan.
    - You become entitled to Medicare benefits.
      - Members have the choice of whether to enroll in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease (ESRD).
  - State continuation Coverage is effective only if we receive your continuation Application and the applicable Prepayment within **31 days** after the date your Group Coverage under this Agreement terminates.
  - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for state continuation Coverage.



- **Eligibility for Individual Conversion Option**
  - If you are still Covered by Presbyterian Health Plan, Inc., at the expiration of any continuation period (whether under COBRA or state law), you will have the option of converting your continuation Coverage to the Individual Conversion Option we provide in accordance with the provisions of the **non-Group Coverage Section**.

- Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for COBRA continuation, state continuation or non-Group/Individual Conversion Option.

- **Conversion to non-Group Coverage (Individual Conversion Option)**
  - You may be eligible to enroll in non-Group coverage as follows:
    - You (on behalf of yourself and your enrolled Dependents) shall have the right to convert to a non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon exhausting the benefits of your COBRA or state continuation coverage.
    - An enrolled Dependent Member under this Agreement shall have the right to convert to a separate, non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon termination of the Dependent's benefit period under COBRA or state continuation, if any.
      - Covered family members of an employee or member of the group insured have the right to continue such coverage through a converted or separate policy upon the death of the member or employee of the group insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the member or employee of the group insured.
  - When your (Subscriber) Dependent Spouse elects Conversion coverage, the Dependent Spouse may include coverage for Dependent children for whom the Dependent Spouse has responsibility for care and support.
  - At the time of Conversion, the Individual Conversion or non-Group coverage provided shall be your choice of one of our available policies. However, at the time of Conversion, if you or your eligible Dependent are eligible for Medicare, the right to convert may be limited to coverage under a Medicare Supplemental Insurance Contract, which are available from other carriers.
  - Individual Conversion Coverage is effective only if we receive your Individual Conversion Application and the applicable Prepayment within **60 days** after the date your Group Coverage under this Agreement terminates.
  - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for the Individual Conversion Option.
  - You, as the Subscriber, may terminate Individual Coverage with no less than **30 days** written notice.

- **Extension of Benefits for the Totally Disabled**
  - In the event you are totally disabled on the date your Group Coverage terminates, healthcare Coverage may be continued for up to **12 consecutive months**. To claim an extension of benefits, you must notify us within **31 days** of the Group Coverage termination date and provide evidence of your total disability.

  - For purposes of this section, totally disabled means that an individual is prevented, solely because injury or disease, from performing their regular or customary occupational duties or is incapable of doing most of the normal activities and tasks for that person's age and family status. In order to qualify for

benefits under this extension, you must have been totally disabled on the date that the Group Coverage terminates, incur an expense directly resulting from that particular disability and such expense would have been a Covered Benefit before termination.

Our Responsibility When Your Group Contract is Replaced

In the event that your contract with another carrier is replaced by Presbyterian due to the prior carrier's discontinuance of the contract, you will be eligible and covered for benefits under this agreement according to the eligibility requirements of this agreement and your employer. Persons not eligible for coverage under this agreement will be covered by Presbyterian if the individual was covered under the previous carrier's plan on the date of discontinuance and if the individual is a member of the class of individuals eligible for coverage under this agreement. Coverage provided will be according to the level of benefits described under this agreement reduced by benefits provided or payable by the prior plan.

Benefits will be provided by Presbyterian until the earliest of the following dates: the date the individual becomes eligible under this agreement and their employer, or the date the individual's benefits would terminate in accordance with termination provisions under this agreement. Conversion privileges will be granted to those individuals whose benefits cease. Presbyterian shall give credit for the satisfaction or partial satisfaction for any Deductibles, Coinsurance, Copayments, or waiting periods that were satisfied under the prior plan providing similar benefits. The credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the Deductible provision of the prior carrier's plan during the **90 days** preceding the effective date of this plan, but only to the extent these expenses are recognized under the terms of this agreement and are subject to a similar Deductible provision.

In any situation where a determination of the prior carrier's benefit is required by Presbyterian, Presbyterian will request the prior carrier to furnish a statement sufficient to permit verification of the benefit determination. The benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of Presbyterian. This determination will be made as if coverage had not been replaced by Presbyterian.

Discontinuance of Your Plan

In the event that 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.

Guaranteed Renewability

An issuer may non-renew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:

- **Nonpayment of Premiums** – The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.
- **Fraud** – The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
- **Violation of Participation or Contribution rules** – In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law. For purposes of this paragraph the following apply:
    - The term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.
    - The term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.
- **Termination of product** – The issuer is ceasing to offer coverage in the market in accordance with paragraph *Discontinuing a particular type of coverage or Discontinuing all coverage* section and applicable State law.
- **Enrollees' movement outside of the service area** – For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; provided the issuer provides notice in accordance with the requirements of *Discontinuing a particular type of coverage* section.
- **Association membership ceases** – For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.
- **Discontinuing a particular type of coverage** – An issuer may discontinue offering a particular type of health insurance coverage offered in the individual market only if it meets the following requirements:
    - Provides notice in writing, in a form and manner specified by the Secretary, to each individual provided coverage of that type of health insurance at least **90 calendar days** before the date the coverage will be discontinued.
    - Offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market.

- Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

- **Discontinuing All Coverage** – An issuer may discontinue offering all health insurance coverage in the individual market in a State only if it meets the following requirements.
  - Provides notice in writing to the applicable State authority and to each individual of the discontinuation at least **180 days** before the date the coverage will expire.
  - Discontinues and does not renew all health insurance policies it issues or delivers for issuance in the State in the individual market.
  - Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
  - For purposes of this section, subject to applicable State law, an issuer will not be considered to have discontinued offering all health insurance coverage in a market in a State if:
    - The issuer (in this paragraph referred to as the initial issuer) or, if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, offers and makes available in the applicable market in the State at least one product that is considered in accordance with 45 CFR § 144.103 of this subchapter to be the same product as a product the initial issuer had been offering in such market in such State; or
    - The issuer:
      - Offers and makes available at least one product in the applicable market in the State, even if such product is not considered in accordance with 45 CFR § 144.103 of this subchapter to be the same product as a product the issuer had been offering in the applicable market in the State;
      - Subjects such new product or products to the applicable process and requirements established under 45 CFR Part 154 of this title as if such process and requirements applied with respect to that product or products, to the extent such process and requirements are otherwise applicable to coverage of the same type and in the same market; and
      - Reasonably identifies the discontinued product or products that correspond to the new product or products for purposes of the process and requirements applied pursuant to paragraph of this section.
  - For purposes of this section, the term, *controlled group,* means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended, or a narrower group as may be provided by applicable State law.
- **Prohibition on market reentry** – An issuer who elects to discontinue offering all health insurance coverage under *Discontinuing all coverage* section may not issue coverage in

the market and State involved during the **five-year** period beginning on the date of discontinuation of the last coverage not renewed.

- **Exception for uniform modification of coverage –**
  - An issuer may, only at the time of coverage renewal, modify the health insurance coverage for a product offered in the individual market if the modification is consistent with State law and is effective uniformly for all individuals with that product.
  - For purposes of *Discontinuing all coverage* of this section, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:
    - The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and
    - The modification is directly related to the imposition or modification of the Federal or State requirement.
  - For purposes of this section, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:
    - The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act), or if the issuer that is a member of a controlled group (as described in *Discontinuing all coverage* section), any other health insurance issuer that is a member of such controlled group;
    - The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);
    - The product continues to cover at least a majority of the same service area;
    - Within the product, each plan has the same Cost-Sharing structure as before the modification, except for any variation in Cost Sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and
    - The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the rate for any plan within the product within an allowable variation of ±2 percentage points (not including changes pursuant to applicable Federal or State requirements).
  - A State may only broaden the standards in paragraphs (iii) and (iv) of this section.
- **Notice of renewal of coverage** – If an issuer is renewing grandfathered coverage as described in *General rules* of this section, or uniformly modifying grandfathered coverage as described in *Exception for uniform modification of coverage* of this section, the issuer must provide to each individual written notice of the renewal at least **60 calendar days** before the date the coverage will be renewed in a form and manner specified by the Secretary.

General Provisions

This Section explains important information and provisions not covered in other sections of this Agreement.

Amendments (Group)

This Group Subscriber Agreement (Agreement) and the Group Letter of Agreement (GLA) shall be subject to amendment, modification, or termination in accordance with their provisions or by mutual agreement in writing between us and the Group. By electing Coverage or accepting benefits under this Agreement, you and all Members legally capable of contracting, agree to all the terms, conditions, and provisions of this Agreement and the GLA.

Assignment

All your rights to receive benefits and services are personal and may not be assigned.

Availability of Provider Services

PHP does not guarantee that a Hospital, facility, Physician, or other Practitioner/Provider will be available in the PHP network.

Conditions of Coverage

Medically Necessary: This health benefit plan helps pay for healthcare expenses that are medically necessary and specifically covered by this plan. Medically necessary means healthcare services determined by a practitioner/provider in consultation the health plan, 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, for the diagnosis or direct care and treatment of physical, behavioral or mental health condition, illness, injury, or disease.

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 amendments, Endorsements, supplements or riders, the GLA, the Employee Action Form and/or Universal/Uniform Medical Assessment Form (Application) completed upon enrollment (if applicable) by the Subscriber

Covered hereunder and our issued Identification Card constitute the entire Contract between the parties and, as of the effective date hereof, supersede all other agreements between the parties.

Execution of Contract – Application for Coverage

The parties acknowledge and agree that your signature or execution of the Application shall be deemed to be your acceptance of the Contract, including the GLA and 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 Employee Action Form and/or Uniform Medical Assessment Form, which is an Application for Coverage.

Federal and State Healthcare Reform

We shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects our obligations under this 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 Healthcare Professional has done any of the items listed below, please call the Practitioner or Provider and ask for an explanation. There may be an error.

- Charged for services that you did not receive
- Billed more than one time for the same service
- Billed for one type of service, but gave you another service (such as charging for one type of equipment but delivering another less expensive type)
- Misrepresented information (such as changing your diagnosis or changing the dates that you were seen in the office)

If you are unable to resolve the issue, or if you suspect any other suspicious activity, please contact our Special Investigative Unit (SIU) hotline at **(505) 923-5959** or **1-800-239-3147**. This confidential voicemail box is available **24 hours** a day. Any information you provide will be treated with strict confidentiality. When reporting suspected health insurance fraud, you may remain anonymous. You can also contact the SIU 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.

HSA Note: Health Savings Account Information

This *Subscriber Agreement* describes only the medical/surgical plan benefits that are available to Members under this plan. Please contact the Health Savings Account (HSA) administrator or financial institution you chose to be the administrator of your HSA about the details of that account, your banking arrangement(s), the amount of money you add to that account, administration fees, and the rules regarding the use of the account to pay for medical expenses not paid under this plan.

Identification Cards

We issue Identification (ID) Cards to you, pursuant to the GLA, 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 Premiums have 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 Healthcare Services.

Legal Actions

No action at law or in equity shall be brought to recover on this Agreement by the Group or a Member prior to the expiration of **60 days** after written proof of loss has been furnished, in accordance with the requirements of this 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 your Employee Action Form, the Universal/Uniform Medical Assessment form or other Coverage Application and/or you provided fraudulent or false information, the Coverage for you and/or your Dependent shall be null and void from the effective date. In the case of fraud, no time limits shall apply, and you will be required to pay for all benefits that we have provided.

Misstatements

No misstatements, except fraudulent misstatements, made by the applicant in the Employee Action Form, the Universal/Uniform Medical Assessment Form or other Application for Coverage for this Contract shall be used to void the Contract or to deny a claim for loss incurred or disability (as defined in this Group 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 Group, Subscriber or Member, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to the Group, Subscriber or Member at the address of record on file at our principal office. The Group is solely responsible for ensuring the accuracy of its addresses and the Subscriber and/or Member is solely responsible for ensuring the accuracy of 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.

Provider Is Family Member

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 or domestic partner) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of their practice.

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 Group or Remitting Agent.

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurance company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurance company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than **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.

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 or the applicable GLA signed by one of the aforesaid officers.

Workers' Compensation Insurance

This plan does not cover services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. This plan does not cover any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization.

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.

Administrative Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding any aspect of a Health Benefits Plan other than a request for Healthcare Services, including but not limited to:

- Administrative practices of the Healthcare Insurer that affects the availability, delivery, or quality of Healthcare Services
- Claims payment, handling or reimbursement for Healthcare Services
- Terminations of Coverage

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Adverse Determination Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding an Adverse Determination.

Agreement means this Group 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).

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 Disorder. These facilities can be standalone (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 a duly licensed transportation service capable of providing Medically Necessary life support care in the event of a life-threatening emergency situation

Annual Group Enrollment Period means a period of at least **10 working days** prior to the expiration of each Contract Year mutually agreed to by our company and the Group, during which eligible Subscribers are given the opportunity to enroll themselves and their eligible Dependents under the Agreement without providing satisfactory evidence of good health.

Annual Out-of-pocket Maximum means a specified dollar amount of Covered Services received in a Contract Year that is the most the Member will pay (Cost-Sharing responsibility) for that Contract Year.

Appeal means a request from a Member, or their representative, or a Practitioner/Provider who is representing a Member, to Presbyterian Health Plan, for a reconsideration of an Adverse Determination (denial, reduction, suspension or termination of a benefit).

Application means the forms, including the Employee Action Form and required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for our Coverage.

Applied Behavioral 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 Healthcare Services both In-network and Out-of-network.

Authorization means a decision by a Healthcare Insurer that a Healthcare Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Healthcare Insurer's requirements for Coverage and Medical Necessity, and the requested Healthcare Service is therefore approved. See **Certification**.

Autism Spectrum Disorder means a condition that meets the diagnostic criteria for the pervasive development disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, including Autistic Disorder; Asperger's Disorder; Pervasive Development Disorder not otherwise specified; Rett's Disorder; and Childhood Disintegrative Disorder.

Balance Billing 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.

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 the five-county area.

Cardiac Rehabilitation means a program of therapy designed to improve the function of the heart.

Certification of Service means a determination by a Health Insurance carrier that a Healthcare Service requested by a Healthcare Professional or Covered Person has been reviewed and, based upon the information available, is a Covered Benefit and meets the carrier's requirements for Medical Necessity, appropriateness, healthcare setting, level of care, and effectiveness, and the requested Healthcare Service is therefore approved. The Certification of Service can take place following the health carrier's utilization review process.

Certified Nurse Midwife means any Person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse-Midwife.

Certified Nurse Practitioner means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the board of nursing.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent Person (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013).

Coinsurance is a Cost-Sharing method that requires a Covered Person to pay a stated percentage of medical or pharmaceutical expenses after the deductible amount, if any, is paid; 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**.

Complications of Pregnancy means conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section are not Complications of Pregnancy.

Continuous Quality Improvement means an ongoing and systematic effort to measure, evaluate and improve a Health Insurance carrier's processes and procedures in order to continually improve the quality of Healthcare Services provided to Covered Persons.

Contract means the Application submitted as the basis for issuance of this Group 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, and the applicable Group Letter of Agreement constitute the entire Contract.

Contract Year means the period, or other length of time covered by the Contract, that we and the Group mutually agree to, as specified in the Group Letter of Agreement (GLA).

Conversion Subscriber means a Member who has converted to our non-Group (Individual Conversion) Membership as a Subscriber, pursuant to the Continuation of Coverage Section.

Copayment is a Cost-Sharing method that requires a Covered Person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the Health Insurance carrier paying the allowed balance; there may be 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 benefits payable extended under this Plan for Covered Health Services provided by Healthcare Professionals subject to the terms, conditions, limitations and exclusions of this Contract.

Covered Person or Enrollee means a Subscriber, policyholder or Subscriber's enrolled Dependent or Dependents, or other individual participating in a Health Benefits Plan.

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

Culturally and Linguistically appropriate manner of notice means the notice that meets the following requirements:

- The Healthcare Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language.
- The Healthcare Insurer must provide, upon request, a notice in any applicable non-English language.
- The Healthcare Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Healthcare Insurer.

For purposes of this definition, with respect to an address in the five-county area 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 Fabricated Orthosis means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

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 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 are 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 means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

- Seen or suspected from a screening examination for breast cancer, or
- Detected by another means of examination

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Doctor of Oriental Medicine means a person licensed as a physician to practice acupuncture and oriental medicine with the ability to practice medicine and collaborate with other healthcare providers. A doctor of Oriental Medicine may serve as a Primary Care Practitioner provided that they are 1) acting within their scope of practice as defined under the relevant state licensing law; 2) meets the PHP eligibility criteria for healthcare practitioners who provide primary care; and 3) agrees to participate and to comply with PHP's care coordination and referral policies.

Domestic Partner A person with whom you have entered into a Domestic Partnership in accordance with the guidelines established by Presbyterian, or if applicable, the Exchange.

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

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

Emergency Care means healthcare procedures, treatments, evaluations or services delivered to a Covered Person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a Reasonable Layperson, to result in:

- Jeopardy to the person's physical or mental health
- 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 Healthcare 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 Group 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 Healthcare Services that are not Covered Services and that we will not pay for.

Experimental or Investigational medical, surgical, other healthcare procedures or treatments, including drugs. As used in this 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 Healthcare Services to eligible children and their families.

FDA means the United States Food and Drug Administration.

Formulary A drug *Formulary*, or preferred drug list, means the list of prescription drugs covered by a policy, plan, or certificate of health insurance, and the tier level at which each drug is Covered under this Plan. Presbyterian 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 Drugs are 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, may be entitled to receive healthcare benefits provided by the healthcare plan.
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Healthcare Purchasing Act.

Group means the legal entity which has contracted with us to obtain the benefits described in this Agreement for Subscribers and eligible Dependents, called Members, in return for periodic Prepayments specified in the Group Letter of Agreement (GLA).

Group Letter of Agreement (GLA) means the administrative agreement between us and the Group.

Group Subscriber Agreement (Agreement) means the booklet which describes the Covered Benefits for which the Member and their eligible Dependents (if any) are eligible for under the terms of the employer's Group Contract.

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 Healthcare Services.

Healthcare Facility means an institution providing Healthcare Services, including a Hospital or other licensed Inpatient center; an ambulatory surgical or treatment center; a Skilled Nursing Facility; a Residential Treatment Center, a Home Health Agency; a diagnostic laboratory or imaging center; and a Rehabilitation Facility or other therapeutic health setting.

Healthcare Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit healthcare plan, fraternal benefit society, vision plan, or pre-paid dental plan.

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

Healthcare Services means service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, to the extent covered by the Health Benefits Plan, a physical or behavioral health service.

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 Healthcare Services to Members who are diagnosed as terminally ill.

Hospital means a facility offering Inpatient services, nursing and overnight care for three or more individuals on a **24-hours**-a-day, **seven-days**-a-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions. 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 Federal Food and Drug Administration for detection of the Human Papillomavirus.

Identification Card (ID or Card) means the card issued to a Subscriber (Member) upon our approval of an Application that identifies you as a Covered Member of your Group Health Benefits Plan.

Immunosuppressive Drugs means Prescription Drugs/Medications used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include, but are not limited to:

- Preventing transplant rejection
- Supplementing chemotherapy
- Treating certain diseases of the immune system (i.e., autoimmune diseases)
- Reducing inflammation
- Relieving certain symptoms
- Other times when it may be helpful to suppress the human immune response

Independent Quality Review Organization (IQRO) means an organization independent of the Healthcare Insurer or managed healthcare organization that performs external quality audits of Managed Healthcare Plans and submits reports of its findings to both the Healthcare Insurer and the managed healthcare organization and to the Division.

In-network Pharmacy means any duly licensed pharmacy, which has entered into an agreement with us to dispense Prescription drugs/Medications to our Members.

In-network Physician means any licensed Practitioner of the healing arts acting within the scope of their license who has entered into an agreement directly with us to provide Healthcare Services to our Members.

In-network Practitioner/Provider means a Practitioner/Provider who, under a contract or through other arrangements with us, has agreed to provide Healthcare Services to Covered Persons, known as Members, with an expectation of receiving payment, other than Cost-Sharing Deductibles, Coinsurance and/or Copayments), directly or indirectly from us.

Inpatient means a Member who has been admitted by a healthcare Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for which there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital. This may also be known as Hospitalization.

Long-term Therapy or Rehabilitation Services means therapies that the Member's Practitioner/Provider, in consultation with us, does not believe will likely result in Significant Improvement within a reasonable number of visits. Long-term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which Rehabilitation Services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome and Cerebral Palsy.

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

Managed Care means a system or technique(s) generally used by third-party payors or their agents to affect access to and control payment for Healthcare Services. Managed Care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services.
- Contracts with selected healthcare Practitioner/Providers.
- Financial incentives or disincentives for Covered Persons to use specific Practitioners/Providers, services, prescription drugs, or service sites.
    - 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 healthcare 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
- 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). A 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. 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 the five-county area, who oversees our Utilization Management Program and Quality Improvement Program, that monitors access to and appropriate utilization of Healthcare Services and that is responsible for the Covered medical services we provide to you as required by New Mexico law.

Medical Necessity or Medically Necessary means Healthcare Services determined by a Provider, in consultation with the Health Insurance carrier, to be appropriate or necessary, according to:

- Any applicable generally accepted principles and practices of good medical care;
- Practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
- Any applicable clinical protocols or practice guidelines developed by the Health Insurance carrier consistent with such federal, national, and professional practice guidelines. These standards shall be applied to decisions the diagnosis or direct care and treatment of a physical, behavioral health condition, illness, injury, or disease.

Medicare means Title 18 of the Social Security Amendments of 1965, "Health Insurance for Aged and Disabled," as then constituted or later amended.

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 Healthcare Services under this Agreement. Also known as an Enrollee.

Mental Health or Substance Use Disorder Services: Means professional services, including Inpatient and Outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including Substance Use Disorder. Additionally, professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act [Chapter 61, Article 9A NMSA 1978].

National Healthcare Network means Out-of-network Practitioner/Providers, including medical facilities, with whom we have arranged a discount for Healthcare Service(s) provided out-of- state (outside of New Mexico).

Nurse Practitioner means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a Certified Nurse Practitioner pursuant to the Nursing Practice Act.

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

Observation Services means Outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under Outpatient observation stay, it is on the Practitioner/Providers written order. Our level of care criteria must be met in order to transition from Observation Services to an Inpatient admission. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient status. Medical criteria will also be considered. Observation for greater than **24 hours** will require **Prior Authorization** by the facility.

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

Organ means an independent body structure that performs a specific function.

Organ Transplant includes parts or the whole of organs, eyes, or tissues.

Orthopedic Appliances /Orthotic Device /Orthosis means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports or eliminates motion of a weak or diseased body part. Examples of Orthopedic Appliances are functional hand or leg brace, Milwaukee Brace, or fracture brace.

Orthotic Appliance means an external device intended to correct any defect of form or function of the human body.

Out-of-network Practitioner/Provider means a healthcare Practitioner/Provider, including medical facilities, who has not entered into an agreement with us to provide Healthcare Services to our Members.

Out-of-network Services means Healthcare Services obtained from an Out-of-network Practitioner/Provider as defined above.

Out-of-pocket Maximum means the most that a Member will pay, in total Cost Sharing, during the Contract Year. Once a Member has reached the Annual Out-of-pocket Maximum limit, we will pay **100%** 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.

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
- 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; in Medicare or retain commercial coverage despite their eligibility for Medicare if they have Ending Stage Renal Disease (ESRD)

PHP means Presbyterian Health Plan, a corporation organized under the laws of the state of New Mexico.

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 Healthcare Professional as defined in Paragraph 2 of Subsection B of Section 59A-22-32 NMSA 1978.

Practitioner/Provider 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 in accordance with the applicable Group Letter of Agreement (GLA).

Prescription Drugs/Medications means those drugs that, by federal law, require a Practitioner's/Provider's prescription for purchase (the original packaging of which, under the federal Food, Drug and Cosmetic Act, is required to bear the legend, Caution: Federal law prohibits dispensing without a prescription or is so designated by the New Mexico State Board of Pharmacy as one which may only be dispensed pursuant to a prescription).

Primary Care Provider/Physician/Practitioner (PCP) means a Healthcare Professional who, within the scope of the professional license, supervises, coordinates, and provides initial and basic care to Covered Persons; who initiates the patient's referral for specialist care, and who maintains continuity of patient care. We designate Practitioners/Providers to be Primary Care Physicians, provided they:

- Provide care within their scope of practice as defined under the relevant state licensing law
- Meet the plan's eligibility criteria for healthcare Providers/Practitioners who provide primary care
- Agree to participate and to comply with a plan's care coordination and referral policies

Primary Care Physicians include General Practitioners, Family Practice Physicians, Geriatricians, Internists, Pediatricians, and Obstetricians/Gynecologists, Physician Assistants and Nurse Practitioners. Other Healthcare Professionals may also **ser**ve as Primary Care Practitioners.

Prior Authorization or Precertification, also known as pre-authorization, means a pre-service determination made by a Health Insurance carrier regarding a Covered Person's eligibility for Healthcare Services based on Medical Necessity, Health Benefits Coverage and the appropriateness and site of service pursuant to the terms of the Health Benefits Plan.

Prosthetic Device means an artificial device to replace a missing part of the body.

Provider means a licensed Healthcare Professional, hospital or other facility authorized to furnish Healthcare Services within the scope of their license.

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 Healthcare Services. A Reasonable/Prudent Layperson is considered to have acted reasonably if,

after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention (including healthcare procedures, treatments, or services) could reasonably be expected to result in:

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

Reconstructive Surgery means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery.
- Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

Registered Lay Midwife means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Rehabilitation Facility means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

Rehabilitation Services means Healthcare Services that help a Member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a Member was sick, injured or disabled. These services may include physical and occupational therapy, and speech-language pathology in a variety of Inpatient and/or Outpatient settings.

Remitting Agent means the person or entity designated by the Group to collect and remit the Prepayment to us.

Rescission of Coverage means a 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.

Retrospective review means a review, sometimes referred to as a retroactive review or post-service Claims request, that is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

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 **https://client.formularynavigator.com/Search.aspx?siteCode=0324498195**. 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) 923-5678**, or **1-800-356-2219**. Hearing impaired users may call **TTY 711**.

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) or other medically necessary conditions. These Special Medical Foods require **Prior Authorization** through Presbyterian's Pharmacy Department.

Specialty Pharmacy – Medications obtained through the Prescription Drug/Medication pharmacy benefit are defined as any drug defined as high-cost medications. These drugs are self-administered meaning they are administered by the patient or to the patient by a family Member or caregiver.

Spouse – Legally married husband or wife.

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

Subscriber means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the Health Benefits Plan, or in the case of an individual Contract, the Person in whose name the Contract is issued.

Substance Use Disorder means dependence on or abuse of substances meeting the criteria as stated in the DSM-5 for these disorders.

Summary of Benefits means a summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective Subscriber or Covered Person by the Health Insurance carrier.

Summary of Benefits and Coverage means the written materials required by state or federal law to be given to the Covered Person/Grievant by the Healthcare Insurer or Contract holder.

Superintendent means The Superintendent of Insurance, the Office of the Superintendent of Insurance (OSI), or employees of OSI acting with the Superintendent's authorization.

Supplemental Breast Examination – 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
- 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 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 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 Healthcare Insurer to a Covered Person/Grievant but does not include a voluntary termination by a Covered Person/Grievant or termination of the Health Benefits Plan that does not contain a renewal provision.

Tertiary Care Facility means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Tobacco means cigarettes (including roll your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, chuttas and dhumti), pipe, smokeless Tobacco (including snuff, chewing Tobacco and betel nut), and novel Tobacco products, such as *eclipse*, *accord* or other low-smoke cigarettes.

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 Practitioner/Providers, the Total Allowable Charges may not exceed the amount the Practitioner/Provider has agreed to accept from us for a Covered service. For Out-of-network Practitioner/Providers, the Total Allowable Charges may not exceed Medicare Allowable Charge as we determine for a service.

Traditional Fee-for-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Covered Persons/Grievants to utilize preferred (In-network) 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 includes 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 Healthcare Insurer consistent with the federal, national, and professional practice guidelines that are used by a Healthcare Insurer in determining whether to certify/authorize or deny a requested Healthcare Service.

Urgent Care means Medically Necessary Healthcare Services provided in urgent situations for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention.

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 Healthcare Services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Utilization Review means a system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

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 Healthcare Practitioner/Provider means any Practitioner/Provider who specializes in Women's Healthcare and who we recognize as a Women's Healthcare Practitioner/Provider.

This Group Subscriber Agreement is issued to the Group for 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 Group Subscriber Agreement.

IN WITNESS THEREOF, Presbyterian Health Plan has caused this Group Subscriber Agreement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN

Tony Hernandez
President
Presbyterian Health Plan, Inc

Exhibit A – Statement of ERISA Rights

The Group healthcare Coverage provided by your employer may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The statement of ERISA rights is applicable to all Group plans except governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens.

If applicable, as a participant in your employer's Group healthcare plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants be entitled to:

Article I. Receive Information about your Plan and Plan Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Section 1.01 Continue Group Health Plan Coverage

- Continue healthcare Coverage for yourself, Spouse or Dependents if there is a loss of Coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such Coverage.
- Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Article II. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining healthcare benefits or exercising your rights under ERISA.

Section 2.01 Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within **30 days**, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to **$110** a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Section 2.02 Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa**, or at the Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210 or contact the U.S. Department of Health and Human Services at **1-877-696-6775** or **www.cciio.cms.gov**. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272**.

Notice of 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 dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.

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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.