PRESBYTERIAN

Central New Mexico Community College (CNM)

Member Benefit Booklet

HDHP PPO Medical Plan

Offered by Central New Mexico Community College (CNM)
Administered by Presbyterian Health Plan, Inc.

MPC122512 01/01/2026

Welcome

This *Member Benefit Booklet* describes the medical benefits offered through the Central New Mexico Community College (CNM).

Our medical plans are self-insured. This means CNM is responsible for the design of the plan and the setting of contributions. We set the contribution rates to be adequate to pay for the claims we all incur. When our claims exceed the contributions, the contribution rates have to go up. We pay less than 10% of the contribution towards the medical plan administration (claims payment, customer service, Provider networking, ID cards, booklets). The balance pays for the cost of our medical care.

All medical plans offer FREE In-Network preventive care. Please take advantage of this benefit after you enroll. Early diagnosis plays a big part in the eventual outcome of any health condition.

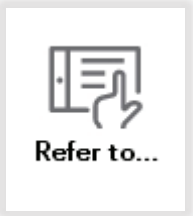
This booklet is intended to provide you with an easy-to-understand explanation of the Plan effective January 1, 2026. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this booklet and the claims administrative procedures of our Third-Party Administrator, Presbyterian Health Plan, Inc., or if any provision is not covered or only partially covered, the terms of the Professional Services Agreement will govern in all cases.

This booklet does not imply a contract of employment. The Central New Mexico Community College reserves the right to terminate, modify, or change this Plan or any provision of this Plan at any time.

It is your responsibility to read and understand the terms and conditions in this booklet. We urge you to read it carefully and use it to make well-informed benefit decisions for you and your family.

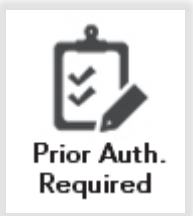
Understanding This Member Benefit Booklet

We use visual symbols throughout this *Member Benefit Booklet* 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 *Member Benefit Booklet* or *Summary of Benefits and Coverage* when necessary. The Section being referenced will be bolded.

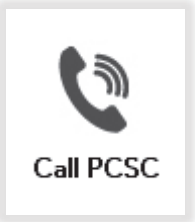
Exclusion – This "Exclusion" symbol will appear next to the description of certain Covered Benefits. The Exclusion symbol will alert you that there are some services that are excluded from the Covered Benefits and will not be paid. You should refer to the Exclusion Section when you see this symbol.



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

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

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



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

In addition, some important terms used throughout this *Member Benefit Booklet* 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) 923-7752** or **1-866-670-0600**. Hearing impaired users may call **TTY 711**. You may visit our website for useful health information and services at **www.phs.org**.

Consumer Assistance Coordinator

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

Written Correspondence

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

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

Introduction

The Central New Mexico Community College (CNM) provides group healthcare coverage through the Preferred Provider Organization (PPO) Medical Plan (Plan) administered by Presbyterian Health Plan, Inc.

This booklet is your *Member Benefit Booklet*. It describes the benefits and limitations of the Plan. It explains how to file claims (if applicable), how to request reconsideration of a claim, or file for an adjustment of a benefit payment.

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

- Providers are Physicians, Hospitals, and other healthcare Professionals or facilities that provide Healthcare Services.
- Preferred Providers have contractual agreements with Presbyterian Health Plan, Inc., and allow lower Out-of-pocket expenses and additional benefits for covered persons.
- Non-preferred Providers do not have contractual agreements with Presbyterian Health Plan, Inc. which may increase the Out-of-pocket expenses and limit benefits for covered persons.

This HDHP Plan allows you to choose, at the time you receive services, the level of benefits that will apply. **You receive the highest benefit level with the lowest cost to you when you obtain services from a Preferred Provider.** *The Presbyterian Health Plan Provider Directory* lists the Preferred Providers. The Provider Directory is available through the Presbyterian website at **www.phs.org** or you can obtain one by contacting the Presbyterian Customer Service Center at **(505) 923-7752** or toll-free at **1-866-670-0600. TTY** users may call **711**.

Additionally, Presbyterian Health Plan now contracts with National PPO Network Provider, a National Preferred Provider organization with over 3,500 acute care Hospitals and 400,000 practitioners. If you live or are traveling outside the state of New Mexico, and require medical attention, we encourage you to see National PPO Network Provider practitioners and facilities. National PPO Network Providers provide care to Presbyterian Health Plan Members at discounted rates, which help keep the cost of medical care down. Additionally, you cannot be charged for any difference between what Presbyterian Health Plan pays the Provider and what the Provider charges beyond your appropriate Copayment, Coinsurance, and/or Deductible (refer to **How the Plan Works Section**). The National PPO Network Provider Directory is available through their website at **www.aetna.com/asa** or you can contact the Presbyterian Customer Service Center, Monday through Friday from 7:00 a.m. and 6:00 p.m. at **(505) 923-7752** (in Albuquerque), or **toll-free** within New Mexico at **1-866-670-0600**. **TTY** users may call **711**.

Please take the time to read this booklet carefully before placing it in a safe place for future reference. If you have any questions regarding this booklet, please call the Presbyterian Customer Service Center, Monday through Friday from 7:00 a.m. and 6:00 p.m. at **(505) 923-7752** or **toll-free** within New Mexico at **1-866-670-0600 (Ask-PRES)**. It is best to call for

clarification before services are rendered to ensure that the proper procedures are followed in order to afford you the maximum level of benefits available under this Plan.

Table Of Contents

How The Plan Works

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

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 a 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.**

Under the Market Stabilization rule finalized on April 13, 2017, to the extent permitted by state law, Presbyterian Health Plan (PHP) may attribute to any past-due premium amounts owed to it the initial premium payment made in accordance with the terms of the health insurance policy to effectuate coverage, for coverage in the 12-month period preceding the effective date. This is done in an effort to prohibit abuse of the grace period. Be aware that failure to pay premiums in a preceding 12-month period may result in the group or individual's inability to effectuate new coverage until past-due premium payments and initial premium payments are satisfied.

In-Network Providers

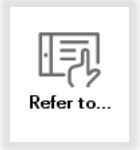
As a Member of this HDHP, for payment to be made you will generally **not** have claims to file or papers to fill out for medical services obtained from In-network Providers. In-network Providers will bill Presbyterian Health Plan directly. Most doctor visits and Hospital Admissions do, however, require Coinsurance and/or Copayments at the time of service. Coinsurance is the percentage of covered charges that you must pay for Covered Services after the Deductible has been met. The amount of your Coinsurance and/or Copayment for each service can be found in the *Summary of Benefits and Coverage*. The Coinsurance will be applied to the Total Allowable Charges or billed charges, whichever is less, for the particular procedure allowed by the Plan.

Out-of-Network Providers

When you obtain care from a Practitioner/Provider who is not in our network (Out-of-network Practitioner/Provider), the Out-of-network Covered Benefits will apply. As shown in the *Summary of Benefits and Coverage*, the benefit levels are lower and your Cost Sharing (Copayments, Deductibles and Coinsurance) amounts are higher.

Additionally, when you receive care from Out-of-network Practitioners/Providers, our payments to them for Covered Services will be limited to Medicare allowable. You will be responsible for any amount due above the Medicare allowable, in addition to any applicable Cost Sharing amount. Medicare allowable is defined in the **Glossary of Terms Section**.

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.



Please refer to your *Summary of Benefits and Coverage*, the **Covered Services Section** and the **Exclusions Section** for a complete listing of Covered and Excluded services.

For Hospital admissions and other services from Out-of-network Practitioners/Providers that require Prior Authorization, you are responsible for ensuring that proper Prior Authorization has been obtained before being admitted to the Hospital or before receiving those services that require Prior Authorization from Out-of-network Practitioners/Providers.

If you are referred to an Out-of-network Practitioner/Provider, services from that Out-of-network Practitioner/Provider are subject to the Out-of-network benefit levels shown in the *Summary of Benefits and Coverage.*

Dialysis Services

The Plan pays 100% of the Medicare Composite Rate Payment Methodology for dialysis services and 100% of the Medicare Average Sales Price Fee Schedule for ESRD drugs; if no allowable is found, then the Plan pays 60% of billed charges for items/services not included in the Medicare Composite Rate.

What is Prior Authorization?

Prior Authorization determines only the medical necessity of a procedure or an Admission and an allowable length of stay. **Prior Authorizations** do not guarantee payment, and do not validate eligibility (for example, to receive non-specified services from a particular Provider). Benefit payments are based on your eligibility and benefits in effect at the time you receive services. **Services not listed as covered and services that are not Medically Necessary are not covered**.

The **Prior Authorization** requirements affect whether the Plan pays for your Covered Services. However, **Prior Authorization** does not deny your right to be admitted to any Hospital.

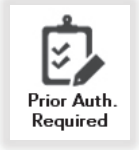
IMPORTANT: If you have Two-Party or Family Medical Coverage, **Prior Authorization** requirements apply to your family Members who are also covered persons.

What Procedures Require Prior Authorization?

Certain procedures or services, as identified in the next subsection of this document, do require **Prior Authorization**. The responsibility for obtaining **Prior Authorization** is as follows:

- In-network Provider - When accessing services from an In-network Provider, the In-network Provider is responsible for obtaining **Prior Authorization** from Presbyterian Health Plan before providing these services to you.
- Out-of-network Provider or National PPO Network Providers - When accessing services from an Out-of-network Provider or a National PPO Network Provider, you are responsible for obtaining **Prior Authorization** from Presbyterian Health Plan before obtaining services from an Out-of-network or National PPO Network. If **Prior Authorization** is **not** obtained when required, then the benefits will be reduced as listed on the *Summary of Benefits and Coverage*.

Prior Authorization – Inpatient



If your In-network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, your In-network Provider is responsible for any **Prior Authorization** requirement for Inpatient Admissions. If an Out-of-network Provider or National PPO Network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, you are responsible for any **Prior Authorization** requirement for Inpatient Admissions. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits and Coverage*.

If Presbyterian Health Plan determines that the Admission was for a covered service, but hospitalization was not Medically Necessary, **no** benefits are paid for Inpatient room and board charges, and these expenses do **not** apply toward the Out-of-pocket Maximum. Other Covered Services are paid as explained in the *Summary of Benefits and Coverage* and the **Covered Services Section**. If the Admission is not for a covered service, **no** payment is made.

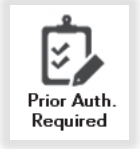
Prior Authorization procedures also apply in the event you are transferred from one facility to another, you are readmitted, or when a newborn child remains hospitalized after the mother is discharged.

Note: All Admissions for Behavioral Health and Alcoholism and/or Substance Use Disorder services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department (1-800-453-4347). If **Prior Authorization** is not obtained prior to rendering service, they may not be Covered if they do not fall within the benefits and limitations of this Plan. For emergencies, Presbyterian Health Plan Behavioral Health Department must be notified by the end of the next business day or benefits may be denied.

Prior Authorization procedures also apply in the event you are transferred from one facility to another, or when a newborn child remains hospitalized after the mother is discharged.

Prior Authorization – Other Medical Services

Prior Authorization requirements are subject to change at the discretion of Presbyterian Health Plan with the approval of the Central New Mexico Community College. Contact our Presbyterian Customer Service Center at **(505) 923-7752** or toll-free at **1-866-670-0600** to verify services requiring **Prior Authorization**.



In addition to **Prior Authorization** for all Inpatient services, **Prior Authorization** is required for the following services. For certain services, **Prior Authorization** may be requested over the telephone. In other cases, a written request for approval must be submitted.

If **Prior Authorization** is not obtained for the following services, benefits will be reduced or denied for all related services. Your In-network Provider will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorizations** with your Provider before obtaining any of the following services:

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

- All Hospital Inpatient Admissions
- Accredited Residential Treatment Center Services (per diem): Chemical Dependency
- Accredited Residential Treatment Center Services (per diem): Psychiatric
- Accredited Residential Treatment Center Services: Substance Use Disorder, In-State
- Applied Behavior Analysis
- 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 Trials (as specified in the **Covered Services Section)**
- Computed Tomography (CT)
- Corneal Cross-linking
- CT Angiography (CTA)
- CV: Mobile Cardiac Outpatient Telemetry (MCOT) and Real-time Continuous Attended Cardiac Monitoring Systems
- Detoxification (acute requiring medical intervention)
- 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
- Gyn: Hysterectomy
- Hip Resurfacing Total
- Hip Replacement Total
- Hypoglossal Nerve stimulation
- Home Health Services
- Hormone Pellet Insertion, Subcutaneous
- Hospice
- Hyperbaric Oxygen
- Injectable drugs over $100 and certain injectables received in the Provider's office
- Inpatient Hospitalization in Freestanding Psychiatric Hospital
- Knee, Arthroscopy
- Knee Replacement Total
- Lumbar/Cervical Spine Surgery
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Medical Supplies greater than $1,000
- 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
- Partial Hospitalization
- Plastic surgery: Panniculectomy and Abdominoplasty and Body Contouring Procedures
- Plastic Surgery: Restorative / Reconstructive / Cosmetic Surgery and Treatment
- Positron Emission Tomography (PET) scans in an outpatient setting

- Prosthetics
- Proton Beam Irradiation
- Respite
- Sacral Nerve Stimulation for Urinary and Fecal Incontinence
- Scans & Cardiac Imaging including Echocardiogram
- Rentals
- Repair or replacement of non-rental DME
- Selected Surgical
- Skilled Nursing Facility (SNF) Services
- Skin Substitutes (Tissue-Engineered / Bioengineered)
- Sleep Studies (In a Facility)
- Sub-acute Residential Treatment Services
- Transcranial Magnetic Stimulation (TMS)
- 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

For National PPO Network Providers/Practitioners, you will be responsible for obtaining Prior Authorization when required. If you obtained Covered Services from a National PPO Network Provider/Practitioner and obtain Prior Authorization when required, benefits will be administered at the higher, In-Network level of benefits.

Case Management Program

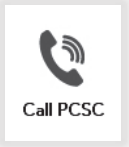
Presbyterian Health Plan's Case Management Program is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive hospitalization, or have complicated discharge planning needs so that cost-effective alternative care arrangements can be made. Special care arrangements are coordinated with the Provider and may include benefits for services that are not ordinarily covered. In addition, the case management program acts to assist the patient and Provider in complex situations and coordinates care across the healthcare spectrum.

PresRN

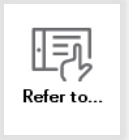
Presbyterian Health Plan members have access to PresRN, a nurse advice line available **24 hours** a day, **seven days** a week, including holidays. PresRN is a no-cost service for Presbyterian Health Plan Members. Please call **(505) 923-5570** or **1-866-221-9679.**

Transition of Care

If you are a new Member and are in an ongoing course of treatment with an Out-of-network Provider, you will be allowed to continue receiving care from this Provider for a transitional period of time (usually not to exceed **90 days**). Similarly, if you are in an ongoing course of treatment with an In-network Provider and that Provider becomes an Out-of-network Provider, you will be allowed to continue care from this Provider for a transitional period of time. Application must be made within **30 days** of the event. Please contact Presbyterian Health Plan's Health Services Department at **1-888-923-5757** for further information on Transition of Care.

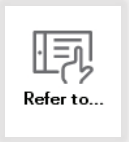


Cost Sharing Features



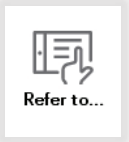
The Plan shares the cost of your healthcare expenses with you. The following describes the different cost-sharing methods available, as detailed in the *Summary of Benefits and Coverage.*

Copayment



For most services obtained from an In-network Provider, you pay a Copayment and the Plan pays a portion of the remainder. The Copayment is stated as a set dollar amount. See the *Summary of Benefits and Coverage* for all applicable Copayments.

Coinsurance



For most services, you will pay a Coinsurance. This is the amount of the covered healthcare expense that is partially paid by the Plan and partially paid by you on a percentage basis. This Coinsurance is in addition to the Calendar Year Deductible you are responsible for and continues to be your responsibility after the Calendar Year Deductible is met. See the *Summary of Benefits and Coverage* for Coinsurance amounts.

Calendar Year Deductible (January 1 –December 31)

Most services are subject to a Calendar Year Deductible. The amount of your Calendar Year Deductible can be found in the *Summary of Benefits and Coverage*. This Deductible must be paid for by you each Calendar Year toward Covered Services **before** health benefits for that Member will be paid by the Plan (except for those services requiring only a Copayment).

For Single and Two-Party Coverage, each Member must meet the applicable individual Deductible as outlined in the *Summary of Benefits and Coverage*. For Family Medical Coverage, an entire family meets their applicable Deductible when the total Deductible amount for all family Members reaches the applicable family amount indicated on the *Summary of Benefits and Coverage*.

Under both Plans, the Deductible for In-Network provider services do not cross-apply to the Out-of-Network Deductible nor vice versa.

Out-of-Pocket Maximum

This Plan includes a Calendar Year Out-of-pocket Maximum amount to protect you from catastrophic healthcare expenses. After your Calendar Year Out-of-pocket Maximum is reached in a Calendar Year, the Plan pays 100%, for Covered Services for the remainder of that Calendar Year, up to the maximum benefit amounts. Refer to the *Summary of Benefits and Coverage* for the Calendar Year Out-of-pocket Maximum amounts.

The Calendar Year Out-of-pocket Maximum includes the Deductible, Copayments and Coinsurance amounts listed in the *Summary of Benefits and Coverage*. Penalty amounts, non-covered charges, and any amounts over Medicare allowable charges are not included in the Out-of-pocket Maximum.

Under the Low Option Plan, amounts applied to your In Network Out-of-pocket Maximum are also applied to the Out-of-network Out-of-pocket Maximum, (until you're In Network Out-of-pocket Maximum is met), and vice versa.

Under the High Option, amounts applied to your In Network Out-of-pocket Maximum are not applied to the Out-of-network Out-of-pocket Maximum, nor are the amounts applied to your Out-of-network Out-of-pocket Maximum applied to the In-network Out-of-pocket Maximum.

Family Out-of-Pocket Maximum

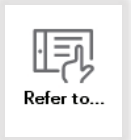
An entire family meets the applicable Out-of-pocket limit when the total Out-of-pocket amount for all family Members reaches the applicable family Out-of-pocket Maximum indicated on the *Summary of Benefits and Coverage*. The *Summary of Benefits and Coverage* also illustrates the Two-Party and Family Out-of-pocket limits. Note: If a Member's individual Out-of-pocket

Maximum is met, no more charges incurred by that Member may be used to satisfy the family Out-of-pocket Maximum.

The Calendar Year Out-of-pocket Maximum includes the Deductible, Copayments and Coinsurance amounts listed in the *Summary of Benefits and Coverage*. Penalty amounts, non-covered charges and any amounts over Medicare allowable charges are not included in the Out-of-pocket Maximum.

If the Plan's Out-of-pocket Maximums change during the year, then the new amounts are in effect during that same Calendar Year. This means that if you have met your lower Out-of-pocket Maximums and then this Plan changes to higher Out-of-pocket Maximums, you do not continue to receive the 100% payment until the increase in the Out-of-pocket Maximum is met during the higher out-of-pocket period. If your Out-of-pocket Maximum amounts decrease, you do not receive a refund for any Out-of-pocket amounts applied during the higher Out-of-pocket period.

Maximum overall



There is no Lifetime maximum payment under the Plan. However, certain benefits are specifically limited and have maximum limits per Calendar Year or lifetime, as described in the *Summary of Benefits and Coverage* and in the **Limitations and Exclusions Section.**

Medically Necessary Services

The Plan helps pay healthcare expenses that are Medically Necessary and for those routine services specifically Covered in this *Member Benefit Booklet*. **No** benefit is available for any expense that is not Medically Necessary, unless it is for a routine service specifically Covered in this *Member Benefit Booklet.*

To be Medically Necessary, tests, treatments, services, or supplies provided by a Hospital, physician, or other healthcare Provider must:

- Be appropriate for the symptoms or diagnosis and treatment of the Member's condition, disease, illness or Accidental Injury;
- Be provided for the diagnosis or the direct care and treatment of the Member's condition, disease, illness or Accidental Injury;
- Be in accordance with the standards of good medical practice in the state where services are provided;
- Not be primarily for the convenience of the Member, the Member's family, or the Member's Provider; and
- Be the most appropriate supply or level of service that can safely be provided to the Member. When applied to hospitalization for acute care, this further means that the

Member requires acute care as a bed patient and cannot receive safe or adequate care in a skilled facility, home health care or Outpatient.

Presbyterian Health Plan determines whether a healthcare service or supply is Medically Necessary and, therefore, whether the expense is covered.

Note: If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a Grievance or complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures" in the **Filing Claims Section**. The fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it Medically Necessary or make the expense a Covered Service, even though it is not specifically listed as an Exclusion.

Healthcare Fraud Message

Insurance fraud may result in cost increases for this healthcare Plan. The following describes ways that you can help eliminate healthcare fraud:

- Be wary of offers to "waive Copayments, Deductibles, or Coinsurance." These costs are passed on to you eventually.
- Be wary of "mobile health testing labs." Ask what the insurance company will be charged for the tests.
- Always review the explanation of benefits (EOB) you receive from Presbyterian Health Plan. If there are any discrepancies, call one of our Presbyterian Customer Service Center representatives.
- Be very cautious about giving information about your insurance coverage over the telephone.

If you suspect fraud, please call the Presbyterian Customer Service Center at **(505) 923-7752** or **1-800-670-0600** Monday through Friday, 7 a.m. to 6 p.m. TTY users may call **711**.

Federal and State Healthcare Reform

Presbyterian Health Plan (PHP) shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any changes in law, or the promulgation of any final rule or regulation which directly affects PHP's obligations under this Summary Plan Description will be deemed automatically amended such that PHP shall remain in compliance with the obligations imposed by such law, rule or regulation.

Health Management

- PHP provides members a number of tools to help better manage all health conditions, including direct access to medical advice any time, day or night through PresRN Nurse Advice Line – **1-866-221-9679**.
- Help with managing chronic conditions through Presbyterian Healthy Solutions program **(505) 923-5487** or **1-800-841-9705**.
- Useful Diabetes education and support through our Certified Diabetes Educators. These resources are available through "Find a Doctor" on **www.phs.org**.

CNM provides group healthcare coverage through the High Deductible Health Plan (HDHP) administered by Presbyterian Health Plan, Inc.

Eligibility, Enrollment and Effective Dates

***This is a summary of the CNM Rules and Regulations. Complete Rules and Regulations are available by visiting www.phs.org/cnm. Rules and Regulations Supersede information contained in this summary.**

Eligible employee

You are eligible to participate in the Central New Mexico Community College Employees Benefits Program if you are actively at work and work the minimum qualifying number of hours established by your employer. In most cases, employees qualify for coverage because they work a minimum of 20 or more hours per week and are eligible upon hire. Regular full-time instructors are eligible upon hire and regular part time instructors who work the equivalent of 30 hours per week or more are eligible based on 12-month lookback period. Coverage starts the first of the month following 30 calendar days of employment.

Eligible Dependents

You may apply to enroll your eligible dependents (spouse and children) to your CNM Group coverage if your dependents meet CNM's eligibility requirements. You will be required to present the original supportive documentation to CNM's benefits office to prove that your dependents meet CNM's eligibility requirements. A copy of the appropriate supportive documentation must accompany your application or change card (or be presented to CNM's benefits office, or uploaded, prior to your coverage going into effect); otherwise, your dependents will experience a delayed effective date of coverage.

As a new hire, your coverage goes into effect upon hire. Please provide the appropriate supportive documentation proving that your dependents are eligible for CNM coverage. In cases of changes in status, you are granted 30 days from the qualifying event to provide the appropriate supportive documentation. In either case, coverage for your dependents will go into effect the first day of the month following the day you turn in the appropriate supportive documentation to CNM's benefits office, or uploaded, (provided you applied timely and meet the 30-day timeline for supportive documentation). The effective date of coverage for your dependents will not be made retroactive to your effective date of coverage, except for newborns and adopted children who are enrolled timely. See details below.

NEWBORN CHILDREN	PLACED FOR ADOPTION OR ADOPTED
You are granted 30 days from the first of the month following your newborn's birth to provide appropriate supportive documentation to CNM's benefits office.	You are granted 30 days from the first of the month following your child's date of placement for adoption or adoption (*whichever comes first*) to provide appropriate supportive documentation to CNM's benefits office.
Coverage for a newborn begins on the newborn's date of birth, provided that you are enrolled in CNM family medical coverage. Any claims associated with your newborn cannot be processed until you apply to enroll your newborn.	Coverage for an adopted child begins on date of placement or adoption (*whichever comes first*) provided that you are enrolled in CNM family medical coverage. Any claims associated with your adopted child, or child placed for adoption cannot be processed until you apply to enroll your child.
If you are not enrolled in CNM family medical coverage, your newborn will not be automatically covered from date of birth. You must apply to enroll your newborn within 30 days from the newborn's date of birth. If you miss this 30-day enrollment period, your newborn will not be eligible for coverage until January 1.	If you are not enrolled in CNM family medical coverage, your adopted child or child placed for adoption will not be automatically covered from date of adoption or placement. You must apply to enroll your child within 30 days from date of placement or adoption (*whichever comes first*) in order for your child's coverage to be effective from date of placement or adoption. If you miss this 30-day enrollment period, your child will not be eligible for coverage until January 1.

The following is a list of dependents that are eligible to participate in your CNM Group coverage. This list also specifies the supportive documentation required to prove your dependent's eligibility:

ELIGIBLE DEPENDENT	SUPPORTIVE DOCUMENTATION REQUIRED
Legal Spouse	Original official state publicly filed marriage certificate from the County Clerk's Office or from the Bureau of Vital Statistics (*chapel certificate is also acceptable*)
Domestic Partner	Notarized affidavit of domestic partnership

Child under the age of 26 as follows: • Natural Child or Stepchildren	Original official state publicly filed birth certificate from the Bureau of Vital Statistics (*hospital birth registration form is also acceptable*)
• Legally adopted child or a child for whom the eligible employee is the legal guardian and who is primarily dependent on the eligible employee for maintenance and support	Evidence of placement by a state licensed agency, governmental agency or a court order/decree (*notarized statement and power of attorney are not acceptable*)
• Child for whom you have legal guardianship	Legal Guardianship Document (*notarized statement and power of attorney documents are not acceptable*)
• Foster child living in the same household as a result of placement by a state licensed placement agency, provided that the foster home is appropriately licensed	Placement order AND foster home license
• Dependent child with qualified medical child support order	Medical Child Support Order
Child enrolled in the CNM Group Plan who reaches age 26 while covered under the CNM Group Plan, who is wholly dependent on the eligible employee for maintenance and support, who is incapable of self-sustaining employment because of mental or physical impairment	Evidence of incapacity and dependency in the form of a physician statement indicating diagnosis, prognosis and application must be provided 31 days before the child reaches age 26 or within 30-days from the date the child becomes incapacitated **while covered under the CNM Group Plan** (*final determination is made by the insurance carrier*).

Ineligible Dependents

The following **ARE NOT ELIGIBLE** for CNA Group Coverage:

- Ex-spouses (even if stipulated in a final divorce decree)
- Dependents while in active military service
- Children left in the care of an eligible employee without evidence of legal guardianship
- Parents, aunts, uncles, brothers, sisters, or any other person not defined as eligible dependent under CNM Rules

Enrollment requirements

You are required to provide Social Security numbers for you and your dependents to enroll in the CNM Group Plan. If you are in the process of applying for a social security number, you may turn in this proof to CNM's benefits office.

You may choose to apply to enroll in single coverage. If you choose to apply to enroll one eligible dependent, you must enroll ALL eligible dependents unless one of the following applies:

1. The eligible dependent for which you are requesting to exclude from a particular line of CNM coverage is covered for that particular line of coverage under another plan (individual, group, Medicaid, Medicare, VA, Indian Health Services, etc.)
2. Coverage starts first of month following 30 calendar days of employment
3. Your enrollment is due to a special event defined under the Special Enrollments Provision, or
4. A divorce decree states that the ex-spouse is to provide a particular coverage for your dependent child

Supportive documentation in the form of a letter from the other plan or employer verifying other coverage is required when #1 applies. (A current insurance identification card is an acceptable form of supportive documentation if it lists the dependent's name and the type of their coverage.)

Supportive documentation as determined by CNM is required when #2 or #3 apply (i.e., evidence of involuntary loss of coverage that specifies who lost what coverage, on what date and why the coverage was lost; original official state publicly filed birth certificate or marriage certificate; divorce decree; etc.).

Change of Status

If you (*or in some cases, your dependents*) have a change of status due to the following qualifying events, you must report this change in status by completing, signing, and turning a change card to CNM's benefits office within 30 days from the qualifying event (*or when you and CNM enter your enrollment on the CNM online benefit system at* **www.phs.org/cnm**):

Qualifying Events

- Birth.
- Marriage.
- Adoption of a child or child placement order in anticipation of adoption.
- Incapacity of a child covered under the CNM Group Plan.
- Legal guardianship of a child.

- Promotion to a new job classification with a salary increase, or employment status change from a part-time position to a full-time position with a salary increase (*provided you are fulfilling the actively-at-work requirement*).
- Divorce or Annulment (*not a legal separation*).
    - You cannot cancel a spouse when a divorce is in progress.
    - You are required to cancel an ex-spouse, effective on the last day of the month your divorce becomes final (you will be required to provide certain pages of your final divorce decree or proof the divorce became final).
    - If you lose other health insurance coverage as a result of divorce, you may apply to enroll in the coverage(s) lost by providing the appropriate supportive documentation listed under the next bullet point.
- Involuntary loss of group or individual coverage through no fault of the person having the group or individual insurance coverage (This may include an involuntary loss of medical insurance, dental insurance, vision insurance, exhaustion of COBRA, etc. IMPORTANT: You will be required to provide CNM's benefits office with a loss of coverage letter specifying who lost coverage, what type of coverage was lost, what day coverage was lost, and why coverage was lost. If the letter does not address each of these factors, we cannot determine the loss of coverage to be an involuntary loss of coverage, and your enrollment may not be accepted.)
- Loss of employment (including retirement).
- Establishment of termination through affidavit terminating domestic partnership.
- Establishment of an affidavit of domestic partnership.
- Death.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependent in the Plan.

You must request enrollment within 30 days after your other coverage involuntarily ends. Exception: You have 60 days from the date of involuntary loss of Medicaid coverage or the children's Health Insurance Program (CHIP) to apply.

Special Enrollment Events for Medical Coverage Only

Special enrollment events mandated by state and federal laws permit you to apply to enroll in medical coverage within 30 days from the occurrence of a special event.

If you meet eligibility requirements for medical coverage and **are not enrolled in the CNM Medical Plan**, you may enroll yourself only, or yourself and one or more eligible dependents for CNM medical coverage within 30 days from the occurrence of the following special events:

- You suffer an involuntary loss of coverage because coverage of your spouse (*or domestic partner, if applicable*) or child under another plan is terminated as a result of divorce,

death, termination of employment, reduction in hours, legal separation, or termination of employer contributions
- You get married or you establish domestic partnership by affidavit. A child is born to you or your spouse
- You adopt a child or a child is placed for adoption in your family
- You or any eligible dependent suffer an involuntary loss of Medicaid or CHIP coverage (*you have 60 days from date of this type of loss to apply; and proof is required*)

To report your change of status due to a qualifying event or a special enrollment event, you are required to complete, sign and turn in a change card and supportive documentation, or you and CNM may enter your change and upload the supportive documentation on the CNM online enrollment system at **www.phs.org/cnm** within 30 days from the date of your qualifying or special event. If you do not meet this 30-day deadline, you may apply for coverage during the established open enrollment in the fall with an effective date of January 1.

Further, if you do not report a change of status that causes your spouse or child to become ineligible either within 60 days from the qualifying event or within 60 days from the day coverage would end; your spouse or child will not be eligible for COBRA continuation coverage under the CNM Group Plan. When a spouse or child becomes ineligible, coverage under CNM Group Plan ends for them on the last day of the month for which they become ineligible. (Even though you have 60 days to report this change as it pertains to COBRA continuation coverage, CNM Rules require that you report this change of status within 30-days from the qualifying event in order to avoid overpayment of premium. This alerts CNM to notify the carriers about your spouse's ineligibility to avoid unnecessary claim payments. This also allows CNM to make the necessary premium adjustments, if any, to your payroll check.)

CNM will retract or collect claim overpayments from you (the employee) when you are late in reporting an ineligible spouse or ineligible dependent.

> **Example #1**: You divorce (or terminate your domestic partnership) on July 12; this causes your ex-spouse (or ex-domestic partner) to become ineligible effective July 31. You should immediately visit your employee benefits office to drop your ex-spouse (or ex-domestic partner) and any enrolled stepchildren (or your domestic partner's children), if applicable, from the CNM Group Plan. Provide your employee benefits office with a copy of your divorce decree (or termination of domestic partner affidavit) and a signed record change card. Your ex-spouse (or ex-domestic partner) may apply for COBRA continuation coverage provided that you report this change of status within the timeframe listed above. (**REMINDER**: *Review your beneficiary designation and make any changes you wish. Life insurance proceeds may not be payable to an ex-spouse unless the ex-spouse is re-designated as beneficiary after the divorce becomes final.)*

When you are electing CNM Group coverage, you will be required to complete, sign, and turn in the appropriate application, or you and CNM may enter your enrollment and upload the supportive documentation on the CNM online benefit system at **www.phs.org**. In the event of a

dependent enrollment, CNM's benefits office is required to view the supportive documentation you have presented. Without the appropriate supportive documentation, your dependent's effective date of coverage will be delayed, if supportive documentation is not provided by the established deadline (*30 days from your effective date or 30 days from the qualifying event), your dependent will not be eligible for coverage until January 1)*.

Address and Phone Number Changes

In order for each insurance carrier affiliated with your CNM coverage to process your address and/or phone number changes, you must report address and phone number changes directly to CNM's benefits office on the appropriate form, or you may enter these changes online at **www.phs.org**.

Termination of Coverage Effective Dates

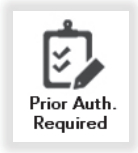
Coverage terminates for CNM Group participation as follows:

- ***Employees*** – Coverage terminates at the end of the period for which deductions are made from your payroll check. This termination date is determined by your employer.
- ***Actively Serving Board Members*** – Coverage terminates on the last day of the month in which the board member's term expires.
- ***Dependents (spouse/domestic partner and dependent child)*** – Coverage terminates on the last day of the month in which the eligible dependent becomes ineligible (i.e., coverage for an ex-spouse and stepchildren or the ex-domestic partner's children terminates on the last day of the month in which the divorce becomes final or domestic partnership terminates; coverage for any other dependent child ends on the last day of the month in which the child reaches the limiting age of 26).
- ***Employees on an extended leave of absence (LOA)*** –CNM determines when your coverage ends under the active plan. CNM's policy may allow you to remain on the active plan for up to one year from the date your LOA was approved, so be sure to contact CNM's benefit office one month prior to reaching this 12-month period to discuss your coverage options. **ALSO**, be sure to contact CNM's benefits office **WITHIN 30 DAYS** from **returning from your LOA** to discuss your benefits or premiums that may have been suspended while you were on LOA. (*Further, if you are on LOA due to disability, be sure to review information regarding benefits you may be eligible for under your life or disability coverage provided by The Standard.*)
- ***Open Enrollment*** – CNM offers open enrollment each fall for medical, dental, and vision coverage. Once you apply (prior to January 1), the change becomes effective on January 1.
- ***The No CNM Double Coverage Rule*** – If both of you and your spouse work for a CNM employer, you and your spouse may not enroll each other as a spouse, nor may you both cover your children. If your child is also an employee of a CNM participating entity and enrolled for employee coverage, you may not cover your child as a dependent for the

lines of coverage your child is enrolled as an employee. Double coverage outside of the CNM Group Plan is allowed.

ID Card

Your Plan ID card identifies the cardholder and your coverage. Carry it with you.



When you present your card to In-network Providers, they know that you receive special benefits – they will file claims for you and will obtain any needed pre-admission review or other **Prior Authorizations**. You are responsible for any Copayments, Coinsurance, or expenses for non-Covered Services.

Your Member identification number and your group number are on your ID Card. Each of your Dependents will also receive an ID card. The reverse side of your ID card provides the address for PHP and some important telephone numbers for your use while using the Plan. It is important that you always show each individual's own ID card when obtaining care.

If you want additional cards or need to replace a lost card, contact a Presbyterian Customer Service Center representative, Monday through Friday, between 7 a.m. and 6 p.m. at **(505)-923-7752** or toll free at **1-866-670-0060**. **TTY** users may call **711**.

This card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits.

Covered Services

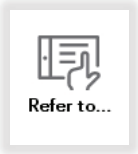
Benefits are subject to the Copayments, Deductibles, and Coinsurance listed in the *Summary of Benefits and Coverage*. Please refer to the **Limitations and Exclusions Section**, for details regarding the Limitations and Exclusions applicable to this Plan. **Any services received must be Medically Necessary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

Note: If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures" in the **Filing Claims Section**.

Accidental Injury/Medical Emergency Care/Urgent Care

Medical Emergency Care

Treatment for a Medical Emergency or Accidental Injury in the Emergency Room of a Hospital or an Urgent Care facility is a benefit. No notification to Presbyterian Health Plan is required. Please refer to the *Summary of Benefits and Coverage* for Emergency Room Visit or Urgent Care Center Copayments and/or Coinsurance. Treatment in a Physician's office or an Ambulatory Surgical Facility is also a benefit and is paid as any other illness.



Emergency - Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to their health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement. (Initial treatment must be sought within 48 hours or as soon as reasonably possible of the accident or onset of symptoms to qualify as emergency care.) Acute Medical Emergency care is available 24 hours per day, seven days a week.

Examples of a Medical Emergency include but are not limited to a heart attack, poisoning, severe allergic reaction, convulsions, unconsciousness, and uncontrolled bleeding.

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

If your emergency treatment requires direct Admission to the Hospital, you are responsible for the Hospital Copayment, but you do not have to pay a separate Copayment/Coinsurance for the emergency room visit.

No notification or **Prior Authorization** is required for Out-of-network (including out-of-state) Hospitals or treatment facilities for Medical Emergency services. Members may be responsible for the Copay and/or Deductible and Coinsurance as outlined on the *Summary of Benefits and Coverage.*

Coverage for trauma services and all other emergency services will continue at least until the Member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the Attending Physician in consultation with Presbyterian Health Plan. Presbyterian Health Plan may request that the Member be transferred to a Hospital participating in its network, if the patient is stabilized and the transfer completed in accordance with federal law.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Urgent Care

The Plan will reimburse for all services rendered in an Urgent Care facility or setting, unless otherwise limited or excluded, if provided by a licensed Provider and/or an appropriate facility for treating urgent medical conditions. Members may contact our Presbyterian Customer Service Center for information regarding the closest In-network facility that can provide Urgent Care.

For Urgent Care, no notification is required. For care obtained from Out-of-network Urgent Care Providers, the Member will be responsible for the Deductible and Coinsurance as outlined on the *Summary of Benefits and Coverage*, as well as those charges above Medicare allowable.

Acupuncture Services

Acupuncture treatment is a benefit only if performed by a licensed Physician, Osteopath, or Doctor of Oriental Medicine acting within the scope of their license.

Benefits for Acupuncture, including office calls, treatment, and Acupuncture are limited as specified in the *Summary of Benefits and Coverage*, in combination with chiropractic, massage therapy services, and Rolfing services. In addition, for ancillary treatment modalities associated with Acupuncture Services, other Plan limitations may apply.

Ambulance Services

Benefits are available for professional Ambulance Services if they are Medically Necessary to protect the life of the Member, and transportation is to the closest Hospital that can provide Covered Services appropriate to the Member’s condition.

Ambulance Service means local transportation in a specially designed and equipped vehicle used only for transporting the sick and injured. Air ambulance is a benefit when Medically Necessary, such as for a high-risk Maternity or newborn transports to a tertiary care facility.

A *tertiary care facility* is a Hospital unit that provides:

- Complete perinatal care occurring in the period shortly before and after birth
- Intensive care of intrapartum patients occurring during labor or delivery
- Prenatal high-risk patients, and
- The coordination of transportation, communication, and data analysis systems for the geographic area served

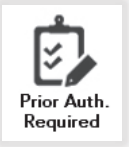
The ambulance Copayment or Deductible and Coinsurance is waived if transportation results in an Inpatient Hospital Admission.

There are no benefits when the ambulance transportation is primarily for the convenience of the Member, the Member's family, or the healthcare Provider.

Behavioral Health and Alcoholism and/or Substance Use Disorder

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

To obtain benefits for Outpatient Services related to Behavioral Health and Alcoholism and/or Substance Use Disorder, it is not necessary to obtain **Prior Authorization**. However, all non-emergency services for Inpatient Behavioral Health and Alcoholism/Substance Use Disorder require **Prior Authorization**. You can call the Presbyterian Health Plan Behavioral Health Department directly at **(505) 923-5470** or **1-800-453-4347** for more information. Emergencies that result in an inpatient admission for Behavioral health and/or Alcoholism /Substance Use Disorder also require **Prior Authorization**. Call Presbyterian Health Plan's Behavioral Health Department at **(505) 923-5470** or **1-800-453-4347** at by the end of the next business day, or as soon as possible, to obtain **Prior Authorization**. If **Prior Authorization** is not obtained, benefits may be denied.



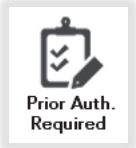
The following benefits and limitations are applicable for Behavioral Health and Alcoholism or Substance Use Disorder Services. In all cases, Behavioral Health treatment and Alcoholism and/or Substance Use Disorder treatment must be Medically Necessary in order to be covered. **Day/visit limitations** listed in the *Summary of Benefits and Coverage* apply to Alcoholism and/or Substance Use Disorder only.

Outpatient services are available from the following credentialed Providers:

- Medical Doctors, Board Eligible or Board Certified in Psychiatry (M.D.)
- Licensed Psychologists (L.P.)
- Licensed Independent Social Workers (L.I.S.W.)
- Licensed Clinical Mental Health Counselors (L.P.C.C.)
- Licensed Marriage and Family Therapists (L.M.F.T.)
- Clinical Nurse Specialists (C.N.S.)
- Licensed Alcohol and Drug Abuse Counselors (L.A.D.A.C.) with master's degree in counseling or social work

If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

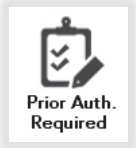
Behavioral Health Services



Inpatient Behavioral Health Services will be covered when performed by a licensed Provider. **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department is required prior to services being provided. Please call **(505) 923-5470** or **1-800-453-4347**.

If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior Authorization** when required, benefits will be administered at the Out-of-network level and Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits and Coverage*.

Partial hospitalization can be substituted for the Inpatient Behavioral Health Services. Partial hospitalization is a non-residential Hospital-based day program attended by the Member at least **three hours** a day but not more than **12 hours** in any **24-hour** period which includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Inpatient Behavioral Health Services require **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits and Coverage.*

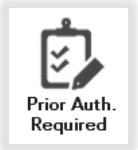


Outpatient, non-Hospital based short-term evaluative and therapeutic Behavioral Health Services will be provided based on medical necessity.

Coverage includes services for diagnostic tests, anesthetics, X-ray and laboratory examinations, and other care provided by a professional Provider, Hospital or Alcoholism treatment center.

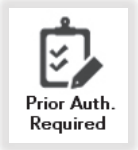
Outpatient services also consist of treatment including; individual, group or family counseling, medication management and neuropsychological testing for Behavioral Health and/or Substance Use Disorder for most Behavioral Health diagnoses. In addition, therapies for marriage, family and relationship problems, physical and/or sexual abuse, and problems related to a mental disorder or medical condition are also a covered benefit.

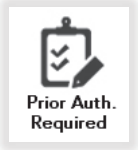
Alcohol and/or Substance Use Disorder Services



Benefits for Alcoholism and or Substance Use Disorder are limited to the number of days listed in the *Summary of Benefits and Coverage*. Inpatient services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department; failure to do so will result in benefits being reduced or denied.

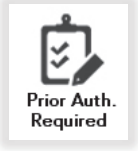
If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior Authorization** when required, benefits will be administered at the Out-of-network level and the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits and Coverage*.





Inpatient treatment in a Hospital or Substance Use Disorder treatment center requires **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. Coverage will be provided up to the number of days listed in the *Summary of Benefits and Coverage* per Member per Calendar Year. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits and Coverage*.

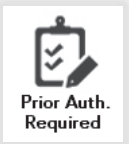
Partial hospitalization can be substituted for Inpatient Alcoholism and/or Substance Use Disorder services. Partial hospitalization is a non-residential day program, attended by the Member at least three hours a day but not more than 12 hours in any 24-hour period, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Partial hospitalization services require **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. Failure to obtain **Prior Authorization** for services may result in a reduction in benefits (as listed on the *Summary of Benefits and Coverage*) or a denial of benefit. Please refer to the *Summary of Benefits and Coverage* for day limitations.



Outpatient, non-Hospital based intensive and standard Outpatient evaluative and therapeutic services for Alcoholism and/or Substance Use Disorder will be covered.

The combined coverage for all Outpatient evaluative and therapeutic Alcohol and/or Substance Use Disorder services (both intensive and standard) is **limited** to the number of visits per Member per Calendar Year listed in the *Summary of Benefits and Coverage*. Intensive Outpatient Alcohol and/or substance use disorder services are defined as visits lasting up to 9 hours per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting between 15 and 110 minutes**.**

Coverage includes services for diagnostic tests, anesthetics, X-ray and laboratory examinations, and other care provided by a professional Provider, Hospital or Alcoholism treatment center.



Treatment in Residential Treatment Centers requires **Prior Authorization** from Presbyterian Health Plan. Failure to obtain **Prior Authorization** prior to services being rendered will result in a denial of coverage. Benefits are available only to members aged 18 and older and are limited as specified on the *Summary of Benefits and Coverage*.

Outpatient services also consist of treatment including individual, group or family counseling, medication management and neuropsychological testing for Behavioral Health and/or Substance Use Disorder for most Behavioral Health diagnosis. In addition, therapies for marriage, family and relationship problems, physical and/or sexual abuse, and problems related to a mental disorder or medical condition are also covered.

Biofeedback

Biofeedback is a benefit when prescribed for the following physical conditions only: chronic pain treatment, Raynaud's disease/phenomenon, tension headaches, migraines, urinary incontinence and craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders. Biofeedback is a benefit only when provided by a Medical Doctor, a Doctor of Osteopathy, or a professional Psychologist.

Benefits for covered Biofeedback Services, including office calls, are limited to the conditions listed above.

Clinical Trials

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

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

participant or beneficiary provides medical and scientific information establishing that the individual's participation would be appropriate.

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

- Conducted under an investigational new drug application reviewed by the Food and Drug Administration
- A drug trial that is exempt from having such an investigational new drug application, OR
- Is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - A cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, OR
    - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the Secretary of Health and Human Services determines that the study has been reviewed and approved through a system of peer review that (i) is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the latest scientific standards by qualified individuals who have no interest in the outcome of the review

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

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

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

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

Cardiac/Pulmonary Rehabilitation

Benefits are available for Outpatient cardiac and/or pulmonary rehabilitation programs. See *Summary of Benefits and Coverage* for appropriate Copayments, Deductible, and/or Coinsurance.

Chemotherapy/Dialysis/Radiation Therapy

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

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

Chiropractic Services

Services administered by a Chiropractor on an Outpatient basis are a benefit, if necessary, for treatment of an illness or Accidental Injury. ***No*** chiropractic benefits are paid for Maintenance Therapy as determined by Presbyterian Health Plan.

Benefits are subject to a Calendar Year limit as shown in the *Summary of Benefits and Coverage*, in combination with benefits for Acupuncture and massage therapy and Rolfing services. In addition, for ancillary treatment modalities associated with chiropractic services, other Plan limitations may apply.

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 Care and Medical Conditions of the Mouth and Jaw

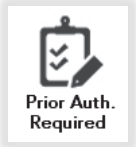
This Benefit has one or more exclusions as specified in the **Exclusions Section.**

Dental Accidents

Treatment for conditions that are the direct result of Accidental Injury to the jaw, sound natural teeth, mouth or face is a benefit. Injury because of chewing, biting, or malocclusion is **not** considered an Accidental Injury.

Sound natural teeth are teeth that are whole or properly restored by amalgams, without impairment, periodontal or other conditions, and not in need of treatment for any reason other than the Accidental Injury. Teeth with crowns or restorations (including dental implants) are not considered sound natural teeth.

To be covered, initial treatment for the injury must be sought within **72 hours** of the accident and any services required after the initial treatment must be associated with the initial accident to be covered. All covered treatments for dental trauma must be completed within one year of the specific traumatic injury, and all services subsequent to the initial treatment require **Prior Authorization** by Presbyterian Health Plan.



If craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders are a result of trauma such as a bodily injury or blow caused solely through external, violent, and unforeseen means, benefits are available for diagnostic examination, X-rays, medications, physical therapy, dental splints, Acupuncture, orthodontic appliances and treatment, crowns, bridges, and dentures. Trauma does not include injury because of biting, chewing, or malocclusion.

When alternative dental or surgical procedures or Prosthetic Devices are available, the dental accident benefit allowance is based upon the least costly procedure or Prosthetic Device. (Dental prostheses may include the placement of dental implants to restore the area of trauma only if it is determined to be the most cost-effective restoration to normal form and function.)

Hospitalization for Dental Care

Benefits are paid for an Ambulatory Surgery Facility or Hospital Outpatient service for dental procedures **only** if the patient has a non-dental, physical condition that makes hospitalization Medically Necessary. The Dentist's services for the procedure may **not be covered**, if determined to be primarily dental in nature and unrelated to the treatment of dental trauma.

Pediatric anesthesia in a day surgical unit may be a covered benefit for pediatric dental procedures if found to be Medically Necessary. The dental procedure itself is **not a Covered Service** unless conditions for trauma or oral Surgery are met.

If a Member is admitted for care, **Prior Authorization** is required. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits and Coverage*. In-network Providers will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to

obtain **Prior Authorization**. Discuss the need for **Prior Authorization** with your Physician. The dental procedure itself is not a covered benefit unless conditions for trauma or oral Surgery are met.

Oral Surgery and TMJ Treatment

Oral dental Surgery benefits are available for cutting procedures for diseases, such as, but not limited to:

- The removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required
- The removal of teeth required due to a side effect from radiation or chemotherapy treatment, before radiation therapy of a cancerous area, or Medically Necessary due to damage from medical treatment (such as prolonged, Medically Necessary use of certain oral medications)
- The external or intraoral cutting and draining of cellulitis (inflammation) that extends beyond the dental space
- The surgical correction of prognathism with handicapping malocclusion, a marked projection of the lower jaw that interferes with chewing
- The removal of bony growths on the jaws and hard palate, unless done in preparation of the mouth for dentures
- The incision of accessory sinuses, salivary glands, or ducts
- The reduction of dislocations such as TMJ Surgery, and
- Lingual frenectomy

Oral dental Surgery benefits require **Prior Authorization** only if admitted. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization,** when required. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician. Oral Surgery procedures that are covered by your dental carrier's coverage are provided **only** if a covered benefit under this Plan. Benefits are payable based upon the Coordination of Benefits (COB) requirements set forth in the **Filing Claims Section**, of this booklet.

Benefits are also available for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders to include surgical and non-surgical treatment including diagnostic examination, X-rays, medications, physical therapy, dental splints, and Acupuncture. Benefits do **not** include orthodontic appliances and treatment, crowns, bridges, or dentures unless the disorder is trauma related. (For treatment due to an Accidental Injury, see "Dental Accidents" in this Section.)

Nonstandard diagnostic, therapeutic, and surgical treatments of Temporomandibular Joint Disorder (TMJ) are **not** benefits under any circumstances. Periodontal Surgery and removal of impacted wisdom teeth are also **not** Covered Services.

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

Diabetes Education

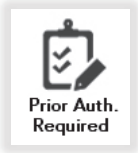
Diabetes education is a covered benefit by referral and includes coverage for any Provider rendering education or instructional services for diabetes. When services are obtained from In-network Providers, the Copayment applies to the professional Provider's services **only.** When services are obtained from Out-of-network Providers, the applicable Coinsurance applies to all services billed.

- Type 1 Diabetes - For all Members, up to six visits to normalize glucose within two months of diagnosis; thereafter, up to one visit per month as needed to maintain control of diabetes. For Members over 18 years of age, up to four visits per year limit for maintaining control.
- Type 2 Diabetes - Up to four visits for initial education, plus if insulin is initiated, up to three visits for insulin start up and management; thereafter, up to four follow up visits per Calendar Year.
- Diabetes Occurring Only During Pregnancy (Gestational Diabetes) - One initial visit; thereafter, two follow up visits per month. In addition, one visit within six months following delivery for conception counseling for patients planning additional children.
- Hypoglycemia and Glucose Intolerance - Up to three visits to provide necessary nutritional counseling to delay or prevent onset of diabetes.
- Insulin Pump Training - One initial session and one follow up session.
- Additional visits - include following a Provider diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; or visits when re-education or refresher training is prescribed by a healthcare Provider with prescribing authority.
- Medically Necessary diabetes education and self-management training visits upon the diagnosis of diabetes.

Diabetes Supplies and Services

The following Diabetes Supplies and equipment are covered for diabetic Members and Members with elevated blood glucose levels due to pregnancy:

- Insulin pump supplies (not to exceed a 30-day supply purchased during any 30-day period)
- Injection aids, including those adaptable to meet the needs of the legally blind
- Insulin pumps
- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, when **Prior Authorization** is obtained from Presbyterian Health Plan, custom molded inserts, replacement inserts, preventive devices, and shoe modifications
- Blood glucose monitors, including those for the legally blind



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 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.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Diabetic Supplies and Equipment- Pregnancy Related

The following supplies and equipment are covered for diabetic Members and Members with elevated blood glucose levels due to pregnancy, not to exceed a one-month supply purchased during any 34-day period:

- Autolet, lancets, and lancet devices
- Insulin pump supplies
- Blood glucose and visual reading urine and ketone test strips
- Injection aids, including those adaptable to meet the needs of the legally blind
- Syringes and needles

The following equipment is also Covered for diabetic Members and individuals with elevated blood glucose levels due to pregnancy:

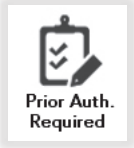
- Insulin pumps if Medically Necessary
- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications
- Glucagon emergency kits
- Blood glucose monitors, including those for the legally blind

Diagnostic Services

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

Diagnostic Services including laboratory tests and X-rays to detect a known or suspected illness or Accidental Injury are covered if ordered by a Provider, including:

- Radiology, ultrasound, and nuclear medicine
- Laboratory and pathology
- Genetic testing unless it is determined to be Investigational (requires **Prior Authorization**)
- Chromosome analysis, including karyotyping and molecular cytogenetic testing (may require **Prior Authorization**)
- EKG, EEG, and other electronic diagnostic medical procedures
- Hearing tests **only** for the treatment of an illness or Accidental Injury (except as outlined below under "Hearing Aids")
- Magnetic Resonance Imaging (MRI) (requires **Prior Authorization**)
- Positron Emissions Tomography (PET) scans (requires **Prior Authorization**)
- Sleep disorders- sleep lab studies can be performed in a certified sleep lab (requires **Prior Authorization**) or
- As part of a home sleep study approved by the Presbyterian Health Plan
- Allergy testing
- Computed Axial Tomography (CAT/CT) (requires **Prior Authorization**)



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

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network

Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

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

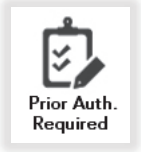
This Benefit has one or more exclusions as specified in the **Exclusions Section.**

Benefits are available for the following items and supplies, when determined to be Medically Necessary:

- The rental or, at the option of Presbyterian Health Plan, the purchase of Durable Medical Equipment when prescribed by a Provider or other professional Provider and required for therapeutic use, including wheelchairs, Hospital beds, crutches, and other necessary Durable Medical Equipment;
- Purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity;
- Prosthetic eyes and prosthodontic appliances;
- Breast Prosthetics when required as the result of a mastectomy;
- Orthotic (a rigid or semi-rigid supportive device) or Orthopedic Appliance (Prefabricated) that supports or eliminates motion of a weak or diseased body part. This does not include foot orthotics, functional or otherwise except for Members with diabetes or other significant neuropathies when Prior Authorization is obtained from Presbyterian Health Plan;
- Custom-fabricated knee-ankle-foot orthoses and/or knee-ankle-foot orthoses (AFO and/or KAFO) for Members up to eight years old;
- Contact lenses for aphakia (those with no lens in the eye) or keratoconus;
- Sclera shells (white supporting tissue of eyeball);
- Initially, either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intra-ocular Surgery or ocular injury and prescribed by a Provider as the only treatment available for keratoconus. The following guidelines apply to eyeglasses provided under this benefit:
    - Only standard frames are Covered. Deluxe frames are not covered.
    - Ultraviolet (UV) protection is Covered.
    - Anti-reflective coating, tints, or oversize lenses are Covered only when they are medically necessary for the individual patient and medical necessity is documented by your treating physician.

- Bifocal lenses in frames or lenses in frames for far vision and lenses in frames for near vision are Covered only when determined to be reasonable and customary.
- Tinted lenses, including photochromatic lenses, used as sunglasses, which are prescribed in addition to regular prosthetic lenses are **not Covered**.
- Scratch resistant coating, mirror coating, polarization and progressive lenses are **not Covered**.
- Lenses made of polycarbonate or other impact-resistant materials are Covered for a patient with functional vision in only one eye.
- Use of polycarbonate or similar material or high index glass or plastic for indications such as light weight or thinness are considered deluxe, and therefore, are **not Covered**.
- Eye glass cases are **not Covered**.
- Duplicates are **not Covered,** and replacement is Covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.

- Hearing aids:
  - Hearing aids and the evaluation for the fitting of hearing aids are Covered for children under 18 years old (or under 21 years of age if still attending high school) The plan pays 100% of the allowed amount up to a maximum of $2,200 every 36 months per hearing impaired ear, thereafter member pays 90% Coinsurance. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit.
  - All other members – hearing aid benefits are limited to a maximum of $500 in benefit payments during any 36-month period, thereafter member pays 90% Coinsurance. This benefit does not include coverage for a hearing test or any charge related to the fitting or prescribing of the hearing aid. The 36-month period is not based on the Calendar Year. The 36-month period begins on the date you purchase your first hearing aid and ends 36 months later. This benefit does include repair and replacement of hearing aids;
- Stethoscopes and manual blood pressure cuffs that are prescribed by a Provider. Automatic blood pressure cuffs or monitors are not covered unless the member is physically unable to use a manual cuff; and
- Repairs or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the Member's condition, or after the product's normal life expectancy has been reached and when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being rendered.



Surgically implantable devices and prostheses are covered as follows:

- Surgically implanted Prosthetics or devices, including penile implants required as a result of illness or injury
- Implantable mechanical devices such as cardiac pacemakers or defibrillators, insulin pumps, epidural pain pumps, and neurostimulators
- Intra-ocular lenses

- Cochlear implants (see "Surgery" for additional information about benefits available for cochlear implantation)
- Teflon®/Dacron® surgical grafts and meshes
- Artificial or porcine heart valves

When alternative Prosthetic/Orthotic Devices are available, the allowance for a Prothesis/Orthosis will be based upon the least costly item.

Medical Supplies

The following medical supplies are covered, not to exceed a one-month supply purchased during any 30-day period:

- Colostomy bags, catheters
- Gastrostomy tubes
- Hollister supplies
- Tracheostomy kits, masks
- Lamb's wool or sheepskin pads
- Ace bandages, elastic supports
- Mastectomy brassieres when required due to a mastectomy (Benefits are limited to six bras per Calendar Year)
- Support hose when prescribed by a Provider for the Medically Necessary treatment of varicose veins (Benefits are limited to 12 pairs or 24 hose per Calendar Year.), and
- Other supplies determined by Presbyterian Health Plan to be Medically Necessary and covered under the Plan

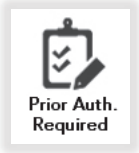
Prior Authorization from Presbyterian Health Plan is required for:

- Durable Medical Equipment, medical supplies (including enteral feeding tubes), orthopedics appliances, orthotics, and surgically implanted Prosthetics; and
- In-network Providers will request Prior Authorization for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain Prior Authorization. Failure to do so may result in benefits being reduced or denied.

For Durable Medical Equipment and supplies under the amount shown in the *Summary of Benefits and Coverage*, **Prior Authorization** is not required. However, Medical Necessity must exist.

Benefits are **not** available for the following items:

- Deluxe equipment such as motor-driven wheelchairs, chair lifts, or beds when standard equipment is available and adequate;
- Rental of Durable Medical Equipment if the patient is in a facility that provides such equipment;
- Cost of repairs that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;
- Dental appliances including dentures;
- Equipment that is primarily non-medical such as heating pads, hot water bottles, water beds, Jacuzzi units, specialized clothing, hot tubs, or exercise equipment;
- Environmental control equipment such as air conditioners, dehumidifiers, or electronic air filters, regardless of the therapeutic value they may provide;
- Accommodative foot orthotics, which are used to accommodate the structural abnormalities of the foot by providing comfort, but not altering function;
- Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by Presbyterian Health Plan), except for Members with Diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan;
- Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints, except for Members with Diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being rendered;
- Custom-Fabricated Orthotics/Orthosis except for knee-ankle-foot Orthosis (AFO and/or KAFO) devices for Members up to eight years old; and
- Duplicate equipment is **not covered** under this Plan.



Family Planning and Related Services

Family planning services are covered for the following procedures (all contraceptives are covered In-network):

- Injection of Depo-Provera for birth control purposes;
- Diaphragm, including fitting;
- Birth control devices, including surgical implantation and removal;
- Intrauterine devices (IUDs) or cervical caps, including fitting, insertion, and removal;
- Prenatal genetic counseling;
- Surgical sterilization procedures such as vasectomies and tubal ligations (If the tubal ligation is done during a delivery, only the Maternity Copayment applies. There will not be an additional Surgery Copayment.); and
- RU486 administered by a Provider.

Only the following infertility-related treatment and testing services are covered (note that the following procedures only secondarily also treat infertility):

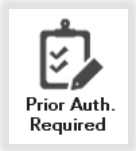
- Surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is not the result of a surgical sterilization; and
- Replacement of deficient, naturally occurring hormones if there is documented evidence of a deficiency of the hormone(s) being replaced.

The above services are **the only infertility-related treatments** that will be considered for benefit payment. Infertility testing is covered only to diagnose the cause of infertility. **Once the cause has been established and the treatment determined to be non-covered, no further testing is covered.** This Plan will also cover testing related to one of the covered treatments listed above (such as lab tests to monitor hormone levels). However, daily ultrasounds to monitor ova maturation are **not covered** since the testing is being used to monitor a non-covered infertility treatment.

This Plan **does not cover** any services or charges for artificial conception including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as artificial insemination, in-vitro ("test tube") or in-vivo fertilization, Gamete Intrafallopian Transfer/Zygote Intrafallopian Transfer (GIFT, ZIFT), all drugs, hormonal manipulation, or embryo transfer is **not a covered** benefit. **Any artificial conception method not specifically listed is also excluded.**

Genetic Inborn Errors of Metabolism Disorders (IEM)

Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the **Limitations and Exclusions Section**, and **Prior Authorization Section** requirements listed in the *Member Benefit Booklet*. Medical services provided by licensed healthcare professionals, including Providers, dieticians and nutritionists, with specific training in managing Members diagnosed with Genetic Inborn Errors of Metabolism (IEM) are Covered. Covered Services include:



- Nutritional and medical assessment
- Clinical services
- Biochemical analysis
- Medical supplies
- Prescription Drugs
- Corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM)
- Nutritional management

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Habilitative

Autism Spectrum Disorder

The diagnosis and treatment for Autism Spectrum Disorder is covered in accordance with the state mandate as follows:

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

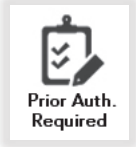
These services are only covered when a treatment plan is provided to Presbyterian Health Plan's Health Services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with the state mandate.

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

Home Health Care

If a Member needs healthcare at home, benefits are available for services provided by a Home Health Agency. This benefit provides Skilled Nursing services when ordered by a Provider and administered in the home on an intermittent basis. A visit is one period of home health service of up to four hours. This benefit conserves Hospital beds for acutely ill patients and reduces the cost of healthcare.

Before the Member receives home health care, the treating Provider or Home Health Agency must request **Prior Authorization** from Presbyterian Health Plan. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician before obtaining services.



The following Home Health Care Services **are covered:**

- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- Physical, occupational, or respiratory/inhalation therapy, by licensed or certified therapists, and speech therapy provided by an American Speech and Hearing Association certified therapist
- Skilled services by a qualified aide to do such things as change dressings, check blood pressure, pulse, and temperature

- Medical supplies, drugs, and laboratory services that would have been provided by a Hospital had the Member been hospitalized
- Provider home visits
- Home Intravenous services
- Enteral feeding equipment and food

There are **no** home health care benefits provided for care that:

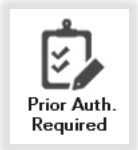
- Is provided primarily for the convenience of the Member or the Member's family
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter, or
- Is provided by a nurse who ordinarily resides in the Member's home or is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

Hospice Care

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

Hospice benefits are available for Covered Services provided by an approved Hospice agency, or Hospital or other facility by or on behalf of a Hospice agency and received during a Hospice benefit period.

Before the Member receives Hospice care, the treating Provider or Hospice agency must request **Prior Authorization in writing** from Presbyterian Health Plan. **Prior Authorization** requires a written treatment program approved by the treating Provider. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician before obtaining services.



The Hospice benefit period must begin while the patient is covered for these benefits, and coverage must be continued throughout the benefit period. The benefit period is defined as beginning on the date the treating Provider certified that the patient is Terminally Ill with a life expectancy of six months or less, ending six months after it began or upon the death of the patient, if sooner.

If the patient requires an extension of the benefit period, the Hospice agency must provide a new treatment plan, and the treating Provider must re-certify the patient's condition to Presbyterian Health Plan. No more than one additional Hospice benefit will be approved.

Benefits are available **only** for, or on behalf of, an approved Hospice agency. An approved Hospice agency must be:

- Licensed when required
- Medicare-certified as a Hospice agency, or
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Hospice agency

The following services **are covered** under this Hospice benefit:

- Inpatient Hospice care
- Hospice care Provider benefits
- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- Home health care by a home health aide
- Physical therapy, speech therapy, or occupational therapy
- Medical supplies
- Drugs and medications for the Terminally Ill Patient

In addition to the Hospice services listed above, you have coverage for:

- Services of a medical social worker (MA or MSW) for patient or family counseling, to include bereavement counseling limited to three visits; and
- Respite care for a period not to exceed ten continuous days. No more than two respite care stays are available during a six-month Hospice benefit period. *Respite care* provides a brief break from total care given by the family.

Hospice benefits are **not** available for the following services:

- Food, housing, or delivered meals
- Medical transportation
- Comfort items
- Homemaker and housekeeping services
- Private duty nursing
- Pastoral and spiritual counseling

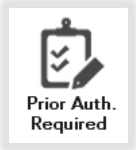
The following services are **not** benefits under Hospice but may be covered elsewhere under this *Member Benefit Booklet*, subject to applicable Copayment and Coinsurance provisions:

- Acute Inpatient Hospital care for curative services
- Durable Medical Equipment
- Non-Hospice care Provider visits
- Ambulance Services

Hospital Inpatient Services

When a Member receives acute Inpatient medical/surgical or pregnancy related Hospital care, benefits are available for covered room and board and other covered Hospital services.

Benefits are available for a non-private room with two or more beds. Private room charges are a covered benefit only when Medically Necessary and when the private room is ordered by the admitting Provider and **Prior Authorization** is obtained from Presbyterian Health Plan. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. If the Member requests a private room or the private room is not Medically Necessary, Presbyterian Health Plan bases payment on the Hospital's average non-private room rate and the Member is responsible for the balance. The balance you pay does not apply to the Out-of-pocket Maximum.



Benefits are available for other room accommodations or Special Care Units such as:

- Intensive Care Unit (ICU)
- Cardiac Care Unit (CCU)
- Sub-Intensive Care Unit
- Isolation Room

If you are re-admitted to a facility (or transferred to a Rehabilitation Hospital or Skilled Nursing Facility) within **15 days** of discharge from an Inpatient facility that was treating you for the same condition, the Copayment for the re-Admission (or transfer) is waived.

Blood

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

Benefits are available for blood transfusions, blood plasma, blood plasma expanders, and the charges for directed donor or autologous blood storage fees **if** the blood is to be used during a procedure that has been scheduled for that Member.

Physical Rehabilitation – Inpatient

Benefits are available for Inpatient rehabilitation services that are Medically Necessary to restore and improve lost functions following illness or Accidental Injury and are provided in Presbyterian Health Plan authorized facilities.

Hospitalization for rehabilitation must begin within one year after the onset of the condition and while the Member is covered under this Plan. Inpatient rehabilitation treatment must be Medically Necessary and **not** for personal convenience.

There are **no** benefits for Maintenance Therapy or care provided after the patient has reached their rehabilitative potential. In the case of a dispute about whether the patient's rehabilitative potential has been reached, the patient is responsible for furnishing documentation from the treating Provider supporting that the patient's rehabilitative potential has not been reached.

Massage Therapy

Only services administered by a licensed Physical Therapist, Licensed Massage Therapist, a Medical Doctor, a Doctor of Osteopathy, a Doctor of Oriental Medicine, or a Chiropractor operating under the scope of their license on an Outpatient basis are a covered benefit, if necessary, for treatment of an illness or Accidental Injury. ***No*** benefits are paid for Maintenance Therapy. Benefits are subject to a Calendar Year limit as shown in the *Summary of Benefits and Coverage* in combination with benefits for Acupuncture and chiropractic services and Rolfing.

Maternity and Newborn Care

Benefits include complete prenatal care, pregnancy related diagnostic tests, prescription drugs, visits to an obstetrician, Certified Nurse-Midwife, or Licensed Midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse-Midwife or Provider. Benefits are available for delivery at home by a Certified Nurse-Midwife or a licensed midwife. Lay midwife deliveries are **not a Covered** Service.

Deliveries by cesarean section, ectopic pregnancies, other pregnancy complications, such as miscarriage, and therapeutic or elective abortions are also Covered.

If Maternity benefits change during a pregnancy, the Member receives the benefits in effect on the day the service is received. Under Two-Party or Family Coverage, a Dependent daughter is eligible for Maternity benefits. Coverage for the newborn is available ***only*** if covered as an eligible Dependent.

Note: Coverage for your newborn begins on your newborn's date of birth, provided that you are enrolled in CNM Family Medical Coverage. (Please contact CNM's benefits office to finalize this enrollment. To avoid delay in claims payments, please finalize this enrollment within 30 days from your newborn's date of birth). **If you are not enrolled in CNM Family Medical Coverage, your newborn <u>will not</u> be automatically covered from date of birth. In such case, you are required to enroll your newborn within 30 days from your newborn's date of birth. (If you miss this 31-day enrollment period, your newborn will fall under the late enrollment provisions of the CNM Rules.) In either case, you will be granted 61 days from the newborn's date of birth to provide your employer's benefits office with your newborn's birth certificate.**

If the newborn is enrolled within **30 days**, the Plan pays benefits for your newborn's services, including newborn visits in the Hospital by the baby's Physician, circumcision, incubator, and routine Hospital nursery charges. If your newborn needs special care including diagnostic tests and Surgery, the Plan pays benefits for that care too. A separate Inpatient Copayment, (or Deductible and/or Coinsurance for Out-of-network care) for your newborn applies only when the infant's Inpatient stay exceeds the mother's date of discharge.

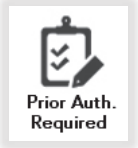
If your newborn stays in the Hospital longer than the mother does, you must notify the Presbyterian Customer Service Center by calling **(505) 923-7752** or toll-free **1-866-670-0600** before the mother is discharged from the Hospital, to coordinate the baby's care, or benefits may be reduced or denied.

Naprapathic Services

Any Covered service of a Licensed Naprapathic, including hand manipulation of connective tissue, intended to release tension and restore structural balance. Benefits are subject to a Calendar Year limit as shown in the *Summary of Benefits and Coverage*.

Newborn and Mothers Health Protection Act

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than **48 hours** following a normal vaginal delivery, or less than **96 hours** following a cesarean section. Plans and insurance issuers may not require that a Provider obtain **Prior Authorization** from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.



If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Provider Services

Please refer to the *Summary of Benefits and Coverage* for applicable Copayments, Deductible and Coinsurance for the following services.

Allergy Services

Benefits are available for direct skin (percutaneous and intradermal) and patch allergy tests and radioallergosorbent testing (RAST).

Chronic Pain Treatment

Chronic pain treatment is a benefit when used for palliative care administered by a licensed Provider only.

Contraceptive Devices

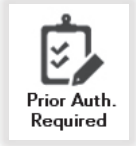
Benefits are available for contraceptive devices that require a prescription by a Provider including:

- IUDs
- Diaphragms
- Other implantable devices

If you must obtain the IUD or a diaphragm from a pharmacy, you will have to pay for the item and then file a claim to the Presbyterian Health Plan. All other contraceptive devices that do not require a prescription are not a benefit.

Injectable Drugs

U.S. Food and Drug Administration (FDA) approved therapeutic injections administered in a Provider's office are covered. However, certain injectable drugs (such as growth hormone and interferon alfa-2) are covered only when **Prior Authorization** is received from Presbyterian Health Plan. Your Presbyterian Health Plan contracted Provider has a list of those injectable drugs that require **Prior Authorization**. If you need a copy of the list, contact one of our Presbyterian Customer Service Center representatives. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization,** when required. Failure to do so may result in benefits being denied.



Presbyterian Health Plan reserves the right to exclude any injectable drug currently being used by a Member that is not specifically listed as covered. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a Presbyterian Health Plan Health Services representative if you have any questions about this policy.

Inpatient Provider Visits and Consultations

Attending Provider visits and consultations in the Hospital are benefits during a covered Admission.

Office Visits

Benefits are available as outlined in the *Summary of Benefits and Coverage*.

Telehealth

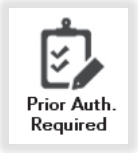
Appointments through video or telephone are with a network Provider, including Presbyterian Medical Group Providers. They require most members to pay a normal Copayment or Cost Sharing, just like with an in-person visit.

Video Visits

Video Visits are provided online between a designated Provider and patient about non-urgent healthcare matters. Benefits are available In-network ONLY, when utilizing the Presbyterian Health Plan myPRES dashboard. Offered at 0% coinsurance on this plan, this convenient option offers a way to see a medical Provider for nonemergency medical conditions via secure video through a smartphone, tablet or computer webcam. For more information, visit **www.phs.org/videovisits**.

Weight Management and Nutritional Counseling

Weight loss management, obesity treatment, and nutritional counseling are not benefits unless dietary advice and exercise are provided by a Provider, licensed nutritionist, or registered dietician. Weight loss management, obesity treatment, and nutritional counseling must be prescribed by a licensed Provider and are a benefit only when Medically Necessary and for a body mass index (BMI - weight in kilograms divided by height in meters squared) of 40 or more.



Some Medical services associated with obesity treatment require **Prior Authorization**. If you access care through an In-network Provider, they will obtain **Prior Authorization** when necessary. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Also, see Morbid Obesity.

Second Opinions

Second opinions are a covered benefit. If a member or Provider requests a second opinion, the applicable office visit Copayment or Deductible and/or Coinsurance will apply. PHP may require a second opinion when questions arise as to the medical appropriateness of a diagnosis or the appropriateness of medical and/or surgical services. In this case, the Copayment, Deductible or Coinsurance will not be charged to the member. PHP will select the Provider for the second opinion.

Preventive Services

Preventive care services are those Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions.

Benefit payments for services listed in this Section are not subject to Copayments for care obtained from In-network Providers or National PPO Network Providers. If the services listed in this Section are obtained from an Out-of-network Provider, **only** applicable Coinsurance applies (Deductible is waived). The services listed below, including the diagnosis of osteoporosis, are covered.

Preventive Health Services for women

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

- Well-woman visits to include adult and female-specific screenings and preventive benefits.
- Breast Cancer: Medication used to reduce risk.
- Breastfeeding comprehensive support, supplies and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for **one year** after delivery.
- Cervical cancer screening for women ages **21 to 65 years** old.
- Chlamydia and gonorrhea screenings for sexually active women age **24 years** or younger and for older women at increased risk for infection.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Coverage for contraception is not subject to cost-sharing, utilization review, **Prior Authorization**, step therapy requirements, or any other restrictions or delays on coverage.
    - Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000007352**
    - Coverage of a six-month supply of contraceptives at one time, provided that the contraceptives are prescribed and self-administered.
- Counseling for HIV, sexually transmitted infections (STIs) and domestic violence and abuse.
- Counseling interventions for pregnant and postpartum persons who are at an increased risk of perinatal depression.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic Acid for the prevention of neural tube defects: preventive medication.

- Gestational Diabetes screening for pregnant women who are **24 weeks** gestation or greater and those at high risk of developing gestational diabetes.
- Human Immunodeficiency Virus (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.
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every **three years** for women with normal cytology results who are **21-65 years** of age.
- HPV Vaccine coverage for the HPV as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).
- Preeclampsia screening in pregnant women throughout pregnancy.
- 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 during procedure are subject to copayment, deductible and/or coinsurance as outlined in your *Schedule of Benefits*.

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/**

Please refer to your formulary on the Pharmacy page at https://client.formularynavigator.com/Search.aspx?siteCode=0045707827to review the list of contraceptive products that will not apply a copayment/coinsurance

Cytologic Screening (Pap smear screening)

Benefits are available to determine the presence of precancerous or cancerous conditions and other health problems in accordance with the national medical standards for women who are 18 years of age or older and for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening.

Evidence-based items or services

Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Service Task Force (USPSTF) with respect to the individual involved.

Immunizations for routine use in children, and adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved.

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

Human Papillomavirus (HPV) Screening

HPV Vaccine Coverage for the Human Papillomavirus, as approved by the Food and Drug Administration, for females 9 to 26 years of age used for the prevention of Human Papillomavirus infection and cervical pre-cancers. In addition, the HPV vaccine is covered for other populations *in accordance with guidelines established by* The Advisory Committee on Immunization Practices (ACIP).

Health Education and Counseling

Health education and counseling services will be provided if recommended by your treating Provider and if consistent with Presbyterian Health Plan policy, including:

- If you are 20 years of age or older, you may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. Included in the consultation may be, but not limited to:
    - Smoking control
    - Nutrition and diet recommendations
    - Exercise plans
    - Lower back protection
    - Immunization practices
    - Breast self-examination
    - Testicular self-examination
    - Use of seat-belts in motor vehicles
    - Other preventive healthcare practices
- If you are under age 20, educational materials or consultation to discuss lifestyle behaviors that promote health and well-being including, but not limited to:
    - The consequences of tobacco and vaping use
    - Nutrition and diet recommendations
    - Exercise plans
    - As deemed appropriate by the Attending Provider or as requested by the parents or legal guardian for children under 18, educational information on Alcohol and Substance Use Disorder, Sexually Transmitted Infections (STIs) and contraception.

Diabetes self-management education programs are also covered when Medically Necessary.

Mammography Coverage

This agreement provides coverage for low-dose screening mammograms for determining the presence of breast cancer. This coverage makes available one baseline mammogram to persons **age 35-39**, one mammogram biennially to persons **age 40-49**, and one mammogram annually to persons **age 50 and over.** After July 1, 1992, coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American College of Radiology accreditation standards for mammography. These scans are covered.

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

Prostate Exams

Benefits are available for certain prostate tests. Guidelines for prostate exams are:

- One screening every year for men 40 to 50 years of age who are at increased risk of developing prostate cancer, and
- One screening every year for men 50 years of age or older

Routine Vision Screening

Routine vision screenings provided by licensed Providers to determine the need for vision correction are a Covered Service and are limited to screening only for Members through age 21. This does not include routine eye exams or refractions performed by eye care Specialists.

Routine Hearing Screening

Routine hearing screenings performed only by licensed Providers to determine the need for hearing correction are a benefit and are limited to screening only for Members through age 21. See additional coverage outlined later in this Section under “Hearing Aids.”

Routine Immunizations

Routine immunizations are not subject to Copayments when provided by an In-network Provider, to include flu shots and other covered adult immunizations including pneumococcal vaccine, diphtheria/tetanus, meningitis, and hepatitis when clinically appropriate as determined by Presbyterian Health Plan. However, you will be responsible for the appropriate

Coinsurance/Deductible if immunizations are obtained from an Out-of-network Provider. Immunizations for travel are not Covered. Immunizations for employment are not a covered benefit.

Routine Physical Examinations

This benefit is not subject to an office visit Copayment when provided by an In-network Provider. It provides coverage for routine annual physical, breast, gynecological and pelvic examinations as well as periodic tests to determine blood hemoglobin, blood pressure and blood glucose level.

Additional services as recommended by the U.S. Preventive Services Task Force:

- Periodic blood cholesterol, or a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level
- Colorectal cancer screening for adults **45** years of age or older
- Periodic left-sided colon examination of 35 to 60 centimeters for Members **age 45** or older
- Periodic glaucoma eye tests for Members **age 35** or older

Employment physicals, insurance examinations, examinations at the request of a third party for premarital; sports, camp, school physicals, international travel and/or other non-preventive services are **not covered**.

The Provider's itemized billing must clearly indicate that the office visit and tests were for preventive care, Well-Child Care, or an annual physical to prevent claim payment being made less a Copayment or Deductible and Coinsurance.

Well-Child Care

Coverage is provided in accordance with the schedule of well-child exams suggested by the United States Preventive Task Force (USPSTF), and the American Academy of Pediatrics/Bright Futures Guidelines.

The Health Resources and Services Administration (HRSA) Bright Futures Program aims to improve health outcomes for the infancies, children, and adolescents by increasing the quality of primary and preventive care through age specific recommendations found here: **https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**.

Rolfing

Rolfing is a covered benefit that is limited as outlined in the *Summary of Benefits and Coverage,* in combination with Acupuncture, Chiropractic, and Massage Therapy. Rolfing must be provided by a certified Rolfer.

Skilled Nursing Facility

A Skilled Nursing Facility provides room and board and Skilled Nursing services for Medical Care and has one or more licensed nurses on duty at all times supervised on a **24-hour** basis by a Registered Nurse (RN) or a Provider, and the services of the Provider are available at all times by an established agreement. The facility must also comply with the legal requirements that apply to its operation and keep daily medical records on all patients.

A Skilled Nursing Facility is not an institution, or part of one, used mainly for rest care, care of the aged, care of Substance Use Disorder treatment, Custodial Care, or educational care.

Prior Authorization is required for Skilled Nursing Facility benefits. This benefit is limited as shown in the *Summary of Benefits and Coverage*. In-network Providers request **Prior Authorizations** for you. Discuss the need for **Prior Authorizations** with your Provider before obtaining services.

Smoking Cessation

Benefits are available for smoking cessation expenses. This benefit includes Acupuncture, hypnotherapy and other recognized smoking cessation programs that are covered through the medical portion of the Plan.

Smoking Cessation Counseling/Program means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow up.
- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying a Member's attendance.
- Employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities.
- Uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

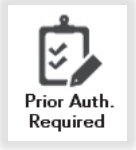
In addition, benefits can be accessed through Express Scripts, your prescription drug Provider, and include Nicorette or any other drug containing nicotine or other tobacco/smoking deterrent medications. All prescription drug claims must be sent as separate claims to Express Scripts, your prescription drug Plan.

Surgery

Benefits are available for the following surgical services:

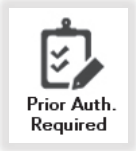
- Necessary anesthesia services by a qualified Provider;
- Sterilization, but **not** procedures to reverse voluntary sterilization;
- Services of a Provider who actively assists the operating surgeon in the performance of a covered Surgery when the procedure requires an assistant, but **not** services of a Provider who is on standby, or available should services be needed; and
- Second or third opinion consultants. The second opinion must be received within six months of when the procedure was recommended. The third opinion must be received within six months of the date the second opinion was given. The Provider giving the second or third opinion must not be the Provider who recommends or performs the Surgery and must practice in a different office than the Provider who recommends or performs the Surgery.

Cosmetic or plastic Surgery or reconstruction procedures, such as breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, micro phlebectomy, sclerotherapy (except when used for truncal veins), nasal rhinoplasty, rhinoplasty, surgical alteration of the eye, and surgical correction of prognathism, that Presbyterian Health Plan determines are not required to materially improve the physiological function of an organ or body part are **not** Covered Services. Services for the reconstruction of surgically induced scars are not benefits under any circumstances. Also, most surgeries require **Prior Authorization.** In-network Providers request **Prior Authorization** for you. Discuss the need for **Prior Authorization** with your Provider.



Bariatric Surgery

Benefits are available for surgical treatment of morbid obesity (bariatric Surgery) **only** when prescribed by a licensed Provider, when Medically Necessary, and with a body mass index (BMI - weight in kilograms divided by height in meters squared) of 35 or more.



Prior Authorization may be required from Presbyterian Health Plan prior to services being rendered. If you access care through an In-network Provider, they will obtain **Prior Authorization,** when necessary. Also, see Weight Management.

Cardiac Surgery

Benefits are available for cardiac Surgery such as those for valve replacements or pacemakers.

Cataract Surgery

Benefits are available for cataract Surgery. The initial placement of either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) will be a covered service.

Contact lenses are also available when necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or ocular injury or prescribed by a Provider as the only treatment available for keratoconus. Services must be Medically Necessary, and further replacement is covered only if a Provider or optometrist recommends a change in prescription. Replacement due to wear, loss or damage is not a covered benefit.

Cochlear Implants

Cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device, is covered.

Congenital Anomalies

Benefits are available for the surgical correction of functional anomalies present from birth. There are **no** benefits for cosmetic procedures or procedures that are **not** Medically Necessary.

Oral Surgery

See "Dental Care and Medical Condition of the Mouth and Jaw" in this Section.

Outpatient Surgery

Benefits are available for Medically Necessary surgical procedures performed in an Outpatient setting (there is no Hospital Admission).

Reconstructive Surgery

Benefits are available for certain types of reconstructive Surgery needed to restore or correct the function of a body part damaged by illness or Accidental Injury.

Reconstructive Surgery that is required because of an Accidental Injury or breast reconstruction subsequent to a mastectomy (breast removal) required as a consequence of disease, is a benefit.

Mastectomy Services

Medically necessary hospitalization related to a covered mastectomy, including at least **48 hours** of Inpatient care following a mastectomy and **24 hours** following a lymph node dissection is covered.

When breast reconstruction is chosen, Covered Services include:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce symmetry between the two breasts, including nipple reconstruction
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas as determined by the Attending Provider and the patient

Breast reconstruction Surgery is limited to a surgical procedure or procedures performed following a mastectomy on one or both breasts to re-establish symmetry between the two breasts. Benefits are also available for procedures related to nipple reconstruction following a mastectomy.

Removal of breast **Prosthesis** is a covered benefit when deemed Medically Necessary. Replacement of the **Prosthesis** is **not** a covered benefit if original placement was due to a cosmetic procedure. Reduction mammoplasty Surgery is covered if the patient meets all the criteria to establish medical necessity.

Note: If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedures" in the **Filing Claims Section**.

Therapy

Physical, Occupational and Speech Therapy

Benefits are limited as shown in the *Summary of Benefits and Coverage* for combined visits per Calendar Year for Outpatient rehabilitation services including physical therapy from a licensed Physical Therapist, and occupational or speech therapy from a licensed or certified therapist. Benefits are **not** available for speech therapy in connection with learning disabilities.

These services may also include treatment using cold, heat, or similar modalities to relieve pain, restore maximum function, and prevent disability following illness, Accidental Injury, or loss of a body part.

Benefits are **not** available for Maintenance Therapy or any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.

Transplant Services

Transplant services include a surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or

tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

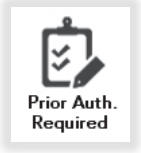
Prescreening at the time of the transplant evaluation and services necessary to complete the evaluation are included in the Transplants benefit as shown in the *Summary of Benefits and Coverage*.

Organ transplant services include the recipient's medical, surgical and Hospital services; Inpatient Immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants;

- Cornea
- Heart
- Kidney/pancreas
- Kidney
- Liver
- Lung
- Pancreas
- Intestine
- Or small bowel/liver

Also covered are islet cell infusion and autologous or allogeneic bone marrow transplants, including peripheral stem cell, as determined to be Medically Necessary. To be covered, transplant services must also be received within one year of the transplant or re-transplant. Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under "Surgery."

The treating Provider or Member must obtain **Prior Authorization** from Presbyterian Health Plan before benefits for any transplant evaluation, procedure or service is provided. **Prior Authorization** must be obtained from Presbyterian Health Plan before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if **Prior Authorization** is not obtained from Presbyterian Health Plan. A Presbyterian Health Plan case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation. In-network Providers request **Prior Authorization** for you. Discuss the need **for Prior Authorizations** with your Provider before obtaining services.



If you are approved as a transplant recipient candidate, you must ensure that **Prior Authorization** for the actual transplant is also received. None of the benefits described here are available unless **Prior Authorization** is obtained.

In addition, benefits are available only when the transplant is performed at a facility with a transplant program approved by Presbyterian Health Plan. Call the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-7752** (in Albuquerque), or toll-free within New Mexico at **1-866-670-0600** for a current list of Presbyterian Health Plan approved programs. TTY users may call **711.**

Call PCSC

Effect of Medicare Eligibility on Coverage: If you are now eligible for or are anticipating receiving eligibility for Medicare benefits, you are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses: If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver are also covered. If there is a living donor that requires Surgery to make an organ available for a covered transplant (e.g., kidney or liver), coverage is available for expenses incurred by the donor for travel (if required, covered under the "Transplant" provision, and approved by the Presbyterian Health Plan case manager), Surgery, organ storage expenses, and Inpatient follow-up care only.

This Plan does not cover donor expenses after the donor has been discharged from the transplant facility.

Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Covered Services related to the transplants are subject to usual cost-sharing features and benefit limitations of this Plan (e.g., Copayments, Deductible/Coinsurance, and out-of-pocket limits; annual home healthcare maximums).

Important Information

Reminder: Benefits are available only when the transplant is performed at a facility with a transplant program approved by Presbyterian Health Plan. The treating Provider or Member must obtain **Prior Authorization** from Presbyterian Health Plan before benefits for any transplant evaluation, procedure or service is provided.

Travel expenses incurred by you in connection with a prior approved organ/tissue transplant are covered subject to the following conditions and limitations. Benefits for transportation, lodging and food are available to you only if you are the recipient of a prior approved organ/tissue transplant from a Presbyterian Health Plan approved Organ Transplant facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for the following:

- Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility)
- Lodging while at, or traveling to and from transplant site
- Food while at or traveling to and from the transplant site
- Travel must occur within five days prior or no more than one year following the actual transplant

In addition to you being covered for the charges associated with the item above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a Member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

By way of example, but not of limitation, the following are specifically excluded travel expenses:

- Travel costs incurred due to travel within 60 miles of your home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products;
- Charges for transportation that exceed coach class rates; and
- These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Travel benefits are available for an adult transplant recipient and one other person, and for a minor transplant recipient, benefits are available for two adults. Transportation costs will be covered only if travel beyond 60 miles of your home is required. Reasonable expenses for lodging and meals will be covered, up to a maximum of $125 per day for each person. All benefits for transportation, lodging, and meals are limited to a maximum payment of $10,000 and are included in the Transplants benefit shown in the *Summary of Benefits and Coverage*.

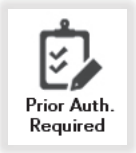
Benefits are not available for implantation of artificial organs, mechanical devices or for non-human organ transplants and those services otherwise listed as covered elsewhere in this booklet. Follow-up care and complications of non-covered transplants are not a covered benefit. Benefits are subject to the same Copayment, Deductible and/or Coinsurance and Out-of-pocket Maximum provisions as other benefits. The cost-sharing provisions of the coverage in effect on the date services are rendered apply to the transplant benefits.

If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedures" in the **Filing Claims Section**.

Wig/Hairpiece

This Plan Covers a wig or hairpiece (synthetic, human hair, or blends) **only** when prescribed by a Physician for hair loss due to injury, disease, or treatment of the following:

- Alopecia areata with near complete or complete cranial hair loss;
- Alopecia total is;
- Alopecia universalis;
- Burns – 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia; Chemotherapy;
- Fungal infections not responsive to an appropriate (typically six week) course of antifungal treatment resulting in near complete or complete cranial hair loss;
- Lupus;
- Radiation Therapy.



Coverage is limited to a maximum of $200 every three years. Annual Deductible and Coinsurance applies. **Prior Authorization** by Presbyterian Health Plan is required. In-network Providers request **Prior Authorizations** for you.

This Plan does **not Cover** wigs/hairpieces for androgenetic alopecia (also known as male patterned baldness).

Limitations And Exclusions

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

If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedures" in the **Filing Claims Section**.

Limitations

The following benefits have limits applied:

Acupuncture treatment Acupuncture treatment benefits for covered expenses, in combination with services provided for chiropractic, Rolfing, and massage therapy, are limited to a Calendar Year Maximum of $1,500 per Member.

Autism Spectrum Disorder - Service 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.

Behavioral Health services (Inpatient) require **Prior Authorization** to be considered an eligible expense under this plan. Behavioral health emergencies that result in inpatient admission also require **Prior Authorization** to be considered an eligible expense under this plan.

Bereavement counseling is limited to **three visits** in conjunction with services provided through Hospice for a terminally ill Member.

Biofeedback treatment is limited to services for Raynaud's disease/phenomenon, urinary incontinence, chronic pain, tension headaches, migraines, craniomandibular joint, and temporomandibular joint (CMJ/TMJ) disorders. Biofeedback is a benefit only when provided by a Provider, a Doctor of Osteopathy, a professional Psychologist, or a Board Certified Biofeedback Therapist.

Chiropractic (manipulations) services for covered expenses, in combination with services provided for Acupuncture, Rolfing, and massage therapy, are limited to a Calendar Year Maximum of $1,500 per Member.

Cochlear implants and related care are limited to implantation of a hearing device to facilitate communication for the profoundly hearing impaired, including any necessary training required to use the device.

Consumable Medical Supplies - Consumable medical supplies are covered during Hospitalization. They are also covered during an office visit or authorized home health visit. Presbyterian Health Plan does not cover supplies used at other times by the Member or Member's family. Consumable medical supplies are:

- Usually disposable
- Cannot be used repeatedly by more than one individual
- Are primarily used for a medical purpose
- Generally are useful only to a person who is ill or injured
- Are ordered or prescribed by a licensed Provider

Contact Lenses or Eyeglasses - Contact lenses or eyeglasses (one set) are limited to services necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or prescribed by a Provider as the only treatment available for keratoconus. Duplicate lenses are not covered; replacement is covered only if a Provider or optometrist recommends a change in prescription due to the medical condition.

Dental Services - This Plan covers only those procedures listed as covered benefits. This Plan does not cover any other oral or dental procedures such as, but not limited to the following:

- Services when **Prior Authorization** is not obtained from Presbyterian Health Plan (except initial treatment of accidental injuries)
- Nonstandard services (diagnostic, therapeutic, or surgical)
- Dental treatment or Surgery, such as extraction of teeth (including wisdom teeth) or application or cost of devices or splints, unless required due to an Accidental Injury
- Removal of impacted teeth; removal of tori or exostoses; procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures
- Duplicate or spare appliances
- Artificial devices and/or bone grafts for denture wear
- Personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth

Diabetic supplies and services that require **Prior Authorization**: Podiatric, Orthopedic Appliances, and Continuous Glucose Monitoring Systems (CGMS).

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

Family planning coverage is limited to Depo-Provera injections, diaphragms, insertion and removal of birth control devices, intrauterine devices (IUDs), prenatal genetic testing, and sterilization procedures.

Hearing Aids are Covered, but the coverage is limited as follows:

- Hearing aids and the evaluation for the fitting of hearing aids are Covered except for school-aged children under 18 years old (or under 21 years of age if still attending high school) up to $2,200 every 36 months per hearing impaired ear. This coverage includes fitting and dispensing services (and ear molds) as necessary to maintain optimal fit.
- Benefits are limited for all other members to a maximum of $500 in benefit payments during any three-year period. This benefit does not include coverage for a hearing test or any charge related to the fitting or prescribing of the hearing aid. **The three-year period is not based on a calendar year. The three-year period begins on the date you purchase your first hearing aid and ends three years later**. This benefit does include repair and replacement of hearing aids. Note: This benefit is also limited to those who are not eligible for the school-aged benefit listed in the previous paragraph.

Home health care services require **Prior Authorization,** or no benefits are payable through the Plan. Discuss the need for **Prior Authorization** with your Provider.

Hospice care benefits are limited to patients who are Terminally Ill as described in the **Covered Services Section**. **Prior Authorization** from the Plan is required, or benefits will be reduced or not payable through the Plan.

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

Infertility treatment is limited to Surgery to open obstructed tubes, epididymis or vasectomy when not the result of sterilization and replacement of deficient hormones if there is documented evidence of a deficiency.

Massage therapy benefits for covered expenses, in combination with services provided for chiropractic, Rolfing, and Acupuncture, are limited to a Calendar Year Maximum of $1,500 per Member. In addition, in order for services to be covered under this Plan, services must be provided by a Physical Therapist, Licensed Massage Therapist, Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine, or a Chiropractor.

Physical, occupational and speech therapy are limited to a Calendar Year maximum as outlined in the *Summary of Benefits and Coverage*.

Preventive services are limited as suggested frequency schedules in the **Covered Services Section.**

Reconstructive Surgery requires **Prior Authorization,** or no benefits are payable through the Plan.

Repairs or replacement of Durable Medical Equipment, Appliances and Devices repair or replacement of non-rental Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices due to normal wear and damage requires **Prior Authorization** or no benefits are payable under this Plan.

Respite care for a Hospice caretaker is limited to **two respite stays** of **up to 10 days** per benefit period.

Rolfing benefits for covered expenses, in combination with services provided for chiropractic, Acupuncture, and massage therapy, are limited to a Calendar Year Maximum of $1,500 per Member.

Routine eye screenings are limited to Dependents through **age 21**.

Routine hearing screenings are limited to Dependents through **age 21**, except as outlined under "Hearing Aids" in the **Covered Services Section**.

Skilled Nursing Care is limited to **60 days** per Calendar Year and is subject to **Prior Authorization** by Presbyterian Health Plan. If you obtain services from an In-network Provider, they will request **Prior Authorization** for you.

Substance Use Disorder benefits are **limited** as follows: Services for any combination of Inpatient, partial, and Outpatient benefits are limited to **30 visits** per Calendar Year and **two courses of treatment per lifetime**. All Inpatient services require **Prior Authorization** to be considered an eligible expense under this Plan.

Transplants and related services include limited benefits for travel, lodging, and meals. These benefits are limited to the adult transplant recipient and one other person. For a minor child transplant recipient, these benefits are payable for two adults. Transportation costs will be covered only if travel beyond 60 miles of transplant recipient's home is required. Lodging and meals are limited to a maximum of $125 per day per person, including the transplant patient. All benefits for transportation, lodging, and meals are limited to a maximum of $10,000. Donor organ procurement costs for the surgical removal, storage, and transportation of the donated organ are covered based on Medicare Allowable.

Weight loss treatment for morbid obesity is subject to Medical Necessity.

Exclusions

Any service, supply, item or treatment not listed as a covered service in the **Covered Services Section**, is **not covered** under this Plan. Benefits are not available for any of the following services, supplies, items, situations, or related expenses.

Activities of daily living are not a covered benefit, to include assistance in bathing, dressing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter.

Adoption/Surrogate expenses are not a covered benefit.

Air ambulance charges for non-emergencies will be covered only if Medically Necessary.

Ambulance (including air ambulance) charges which are not Medically Necessary are **not covered** services under this Plan. This includes but is not limited to transfer via ground/air ambulance to a lower level care facility or the patient's home.

Amniocentesis and/or ultrasound to determine the gender of a fetus are **not covered** benefits under this Plan.

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

Autopsies are not a covered benefit under this Plan.

Before effective date benefits are not available for that portion of any Inpatient treatment provided before the Member's effective date or for any service or supply received before the Member's effective date under this Plan.

Behavioral disorders are not a covered benefit under this Plan unless associated with a manifest mental disorder.

Behavioral Health and Alcoholism and/or Substance Use Disorder for the following are **not covered**:

- Any care which is patient elected and is not considered Medically Necessary
- Care which is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider
- Workers' Compensation or disability claims are **not covered** as part of treatment
- Long term Custodial Care of children and adolescents

- Special education, school testing and evaluations, counseling, therapy or care for learning deficiencies or education and developmental disorders
- Behavioral problems unless associated with manifest mental illness or other disturbances
- Non-national standard therapies, including Experimental as determined by the Behavioral Health professional practice

Behavioral training is not a covered benefit under this plan.

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

Charges:

- In excess of Plan limits.
- In excess of Medicare Allowable Amounts when services are secured from an Out-of-network Provider. (This may not apply to Emergency Medical services or Urgent Care services. See the **Limitations and Exclusions Section** for more information.)
- Made by a family Member (spouse, parent, grandparent, sibling or child) or someone who lives with you.

Clinic or other facility services that the Member is eligible to have provided without charge.

Complications of non-benefit services, supplies and treatment received including, but not limited to, complications for non-covered transplants, cosmetic, Experimental, or Investigational procedures, sterilization reversal, or infertility treatment are **not** Covered Services.

Contact lenses or eyeglasses unless specifically listed as a covered benefit under this Plan.

Convalescent care or rest cures.

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

Counseling services are not a covered benefit under this Plan unless listed as a covered service. Exceptions to this exclusion include but are not limited to prenatal genetic counseling, counseling for breastfeeding support, bereavement counseling related to hospice care, counseling programs for tobacco cessation, nutritional counseling (when medically necessary), and therapies for marriage, family, and relationship problems, physical and/or sexual abuse, and problems related to a mental disorder or medical condition.

Court ordered services are not a covered benefit under this Plan.

Custodial Care such as sitters, homemaker services, or care in a place that serves the patient primarily as a residence when the Member does not require Skilled Nursing Care is **not covered**.

Dental services to include periodontal Surgery except if the services required are due to Accidental Injury of sound natural teeth or as otherwise listed as a covered Benefit under this Plan.

Dependent of Dependent (grandchild) expenses are **not covered** benefits unless the Dependent is otherwise eligible for coverage under this Plan.

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

Diagnostic, therapeutic, rehabilitative or health maintenance services provided at or by a health spa or fitness center, even if a licensed or registered Provider provides the service, are **not covered.**

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

Donor expenses incurred by a Member are not a covered benefit under this Plan, except as specified in this *Member Benefit Booklet*.

Duplicate coverage including, but not limited to, the following:

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

Duplicate diagnostic tests or over reads of laboratory, pathology, or radiology tests are not covered.

Duplicate equipment is **not covered** under this Plan.

Durable Medical Equipment, orthotic and Prosthetic Devices and external prostheses repairs for items not owned by the Member, or which exceed the purchase price.

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

Environmental control expenses are not covered benefits under this Plan.

Exercise equipment is not a covered benefit under this Plan.

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

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

Eye exercises and refractions are not a covered benefit under this Plan.

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

Foot care, including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone Surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails, are **not covered** unless medical conditions such as Diabetes exist.

Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by Presbyterian Health Plan) are not covered, except for Members with Diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided.

Genetic Inborn Errors of Metabolism (IEM):

- Food substitutes for lactose intolerance including soy foods or formulas or other over the counter digestive aids
- Organic foods
- Ordinary foodstuffs that might be part of an exclusionary diet
- Food substitutes that do not qualify as Special Medical Foods
- Any product that does not require a Physician's prescription

- Special Medical Foods for conditions that are not present at birth
- Food items purchased at a health food, vitamin or similar store
- Foods purchased on the Internet
- Special Medical Foods for conditions including, but not limited to, Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, and Allergies to food products

Hair loss, including wigs, artificial hairpieces, hair transplants, or implants, even if there is a medical reason for hair loss are **not covered**.

Hearing aids
Hearing aids and the evaluation for the fitting of hearing aids are not Covered except for school aged dependent children under 18 years old (or under 21 years of age if still attending high school):

- The Plan pays 100% of the allowed up to a maximum of $2,200 every 36 months per hearing impaired ear for school aged dependent children.
- Coverage includes fitting and dispensing services, including ear molds as necessary to maintain optimal fit.

Hearing Exams and procedures
This Plan does not cover audiometric (hearing) tests unless:

- Required for the diagnosis and/or treatment of an illness or Accidental Injury
- Covered as a preventive screening service for children through age 21 as part of a routine physical exam, or
- Covered as outlined under "Hearing Aids" above

For surgically implanted devices, see "Surgery" in the **Covered Services Section**.

Home health care benefits are **not covered** for care that:

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

Hospice benefits are not available for the following services:

- Food, housing, or delivered meals
- Medical transportation
- Comfort items
- Homemaker and housekeeping services
- Private duty nursing

- Pastoral and spiritual counseling
- Volunteer services
- Support services provided to the family when the patient is not a Member of this Plan

Additionally, the following services are not benefits under Hospice but may be covered elsewhere under this booklet:

- Acute Inpatient Hospital care for curative services
- Durable Medical Equipment
- Non-Hospice care Provider visits
- Ambulance Services

Human Chorionic Gonadotrophin (HCG) injections are not a covered benefit under this Plan.

Hypnotherapy or services related to hypnosis, whether for medical or anesthetic purposes, except as covered under "Smoking Cessation Treatment." are **not covered**.

Implantation of artificial organs or mechanical devices, except as specified in this booklet, are not a covered benefit under this Plan unless as a result of illness or injury and **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided.

Infertility testing and treatment is not a covered benefit under this Plan, except as specified in this document. Also, see the exclusion under Artificial Conception.

Intradiscal Electrothermal Therapy (IDET) is not a covered benefit under this Plan.

Late claims filing: This Plan does not cover services submitted for benefit determination if Presbyterian Health Plan receives the claim **more than 12 months** after the date of service. **Note**: If there is a change in the Claims Administrator, the length of this timely filing period may also change.

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

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

Long-term rehabilitation services are not covered. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief.

Maintenance or long-term therapy or care or any treatment (Inpatient or Outpatient) that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice benefit

period) is **not covered** under this Plan. In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your Provider supporting their opinion that your rehabilitative potential has not been reached. **Note**: Even if your rehabilitative potential has not yet been reached, this Plan does not cover services that are in excess of maximum benefit limitations.

Massage therapy is **not covered** under this Plan unless performed by a Licensed Physical Therapist, Licensed Massage Therapist, medical doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

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

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

Membership fees are not a covered benefit under this Plan.

Meniscal Transplants are not a covered benefit under this Plan.

Mobile or temporary testing units who submit a bill to this Plan will have those charges denied, including services for pap smears, OB/GYN services, adult general screening and physicals.

Non-covered Providers: Services from non-covered Providers are not covered under this Plan. Non-covered Providers include members of your immediate family or one normally residing in your home, health spas or health fitness centers, school infirmaries (except for Student Health Centers at institutions of higher education), private sanitariums, nursing homes, rest homes, or dental or medical departments sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.

Non-human organ transplants are **not covered** under this Plan

Non-medical equipment is **not a covered** benefit under this Plan.

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

Nonprescription and over the counter drugs are **not covered** on this Plan. This also includes:

- Infertility medications
- Non-medicinal substances, regardless of intended use
- Medications or preparations used for cosmetic purposes, such as preparations to promote hair growth or medicated cosmetics, or
- Charges for the administration or injection of any drug, including allergens or allergy shots unless elsewhere covered in this booklet

Nonstandard or deluxe equipment is not a covered benefit under this Plan.

Nutritional supplements are not a covered benefit under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a covered benefit.

Obesity treatment is not a covered benefit under this Plan unless the Member is being treated for morbid obesity.

Orthodontic appliances and treatment, crowns, bridges, or dentures for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders are **not covered** on this Plan unless the disorder is trauma related. Also, nonstandard diagnostic, therapeutic and surgical treatments of TMJ are not benefits under any circumstances.

Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints are not covered, except for Members with Diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan.

Orthoptics are not a covered benefit under this Plan.

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

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

Photopheresis for all conditions other than mycosis fungoides are **not covered.**

Physical examinations and/or immunizations for purposes of employment, insurance, premarital or international travel tests, sports, school, camp, other non-preventive tests, and those requested by a third party, are **not covered** under this Plan unless considered Medically Necessary by the Plan.

Post-termination care: This Plan does **not Cover** services received after your coverage is terminated, even if **Prior Authorization** for such services were needed because of an event that occurred while you were covered. Benefits are available for Covered Services related to and

received during a Covered Hospital Admission that began before coverage ended. Coverage for the Admission and related Inpatient services continues until the earlier of the date: 1) benefits for the Admission are exhausted, or 2) when there is an interruption of the Inpatient stay (such as discharge or a leave of absence from the facility, regardless of the date of discharge).

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

Protective clothing or devices are **not covered** under this Plan.

Radial keratotomy, LASIK and other eye refractive surgeries are **not covered** benefits under this Plan.

Reversals of surgical procedures are not a covered benefit under this Plan.

Self-help programs and therapies not specifically covered in this booklet are **not covered** by the Plan. These include but are not limited to, behavior modification; music, art, dance, recreation and Z therapy; massage therapy except when performed by a Licensed Physical Therapist, a Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

Services not specifically identified as a benefit in this booklet, or **services not listed as a covered benefit** in this booklet.

Sexual dysfunction testing and treatment, unless related to organic disease or Accidental Injury are **not covered** under this Plan

Speech therapy charges not otherwise listed as a covered benefit under this Plan are **not covered.**

Sperm storage is not a covered benefit under this Plan.

Standby professional services are **not covered** under this Plan.

Surgical sterilization reversal of voluntary infertility procedures is **not covered** under this Plan.

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

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

Travel and other transportation expenses, except as covered under "Ambulance Services" and "Transplants" are **not covered**.

Treatment for injuries sustained by a Member in the course of committing a felony, if the Member is subsequently convicted of the felony is not covered.

Unreasonable charges will not be covered by this Plan.

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

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

Vision care: The Plan does not cover eyeglasses, contact lenses, and routine eye refractions unless listed as covered in this booklet.

Vision therapy or any surgical or medical service or supply provided in connection with refractive keratoplasty (Surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct myopia, or any procedure to correct refractive defects such as farsightedness, presbyopia, or astigmatism are **not covered.**

Vitamins, dietary/nutritional supplements, special foods, formulas, or diets are **not covered** under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a Covered Service.

Vocational rehabilitation services are not a covered benefit under this Plan.

War-related conditions: This Plan does not cover any services required as the result of any act of war, or any illness or Accidental Injury sustained during combat or active military service.

Weight-loss programs, obesity treatment, and nutritional counseling, except as outlined in the **Covered Services Section**.

Work-related conditions: This Plan does not cover services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- Occupational disease laws
- Employer's liability
- Municipal, state, or federal law (except Medicaid), or
- Workers' Compensation Act

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (Presbyterian Health Plan may pay claims during the appeal process on the condition that

you sign a reimbursement agreement with Presbyterian Health Plan as the claims administrator for the Plan.)

This Plan does not cover a work-related illness or injury, 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.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for a participant's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

Note: This "Work-related condition" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and that you are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

Filing Claims

This is an HMO-type Plan wherein the In-network Providers have agreed to file your claims directly to Presbyterian Health Plan and payment is made directly to the Provider.

On occasion you may access care from an Out-of-network Provider such as in an emergency when you are traveling out of the service area. In such cases you may have to file a claim yourself.

Emergency Services or Out-of-Network Providers

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

You will be required to submit claim forms when your Out-of-network Provider does not file them for you. Submit all claims as the services are received and attach the itemized bill for services or supplies. Do not file for the same service twice unless requested by one of our Presbyterian Customer Service Center representatives.

The Member Claim Forms are available from a Presbyterian Health Plan Member Services representative, who can also answer your questions about completing the claim form. Claim forms can also be printed from the Presbyterian website at **www.phs.org**. Please mail the claim forms and itemized bills to:

Presbyterian Health Plan, Inc.
Attn: CNM HDHP Claims
P.O. Box 27489
Albuquerque, NM 87125-7489
(505) 923-5600 or toll free at 1-888-275-7737

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

Out-of-Network Service Claims

When you obtain Provider or Outpatient Hospital services from an Out-of-network Provider, the Provider, Hospital Provider, or you should file the claims with Presbyterian Health Plan. If the Provider or Hospital does not file the claims, ask for an itemized statement and complete a Presbyterian Health Plan claim form for the services received from the Out-of-network Provider. The Provider may require that you pay for services up-front and then wait for the Presbyterian Health Plan to process the claim (see “How Payments are Made” below). Out-of-network Providers are not required to accept the Presbyterian Health Plan determined allowable amount

as payment in full and may balance-bill you the difference between the allowed amount of this Plan and the amount they charged for their services.

Claims Outside the United States

Coverage outside the United states is limited to Emergency and Urgent Care only. Members are responsible for ensuring that claims are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States. The Provider may require that you pay for services up-front and then wait for Presbyterian Health Plan to process the claim. (See "How Payments are Made" below).

Itemized Bills

When you file a claim, itemized bills must be submitted on the Provider's billing forms or the Provider's letterhead stationery and must show:

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

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

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

Prescription Drug Claims

If you need to submit a claim for Presbyterian Drugs, that claim must be sent to the Prescription Drug Plan Administrator, not a Presbyterian Health Plan. Please refer to Express Scripts brochure or call them at **1-800-501-0987** for the claims filing procedures for Prescription Drugs.

How Payments are Made

Payments for Covered Services usually are sent directly to In-network Providers, including preferred Hospitals/treatment facilities. Payments to Out-of-network Providers are sent to the Member unless the Member has assigned benefits to the Provider.

Provider payments are based upon In-network Provider agreements and the Negotiated Fee for Service as determined by Presbyterian Health Plan. You are responsible for paying all Copayments, Coinsurance, and non-Covered Services.

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

Payment of benefits for Members eligible for Medicaid is made to the New Mexico Health Care Authority or to the Medicaid Provider when required by law.

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

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

Overpayments

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

When possible, this Plan will honor an assignment of benefits; however, Presbyterian Health Plan reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits to pay anyone other than the subscriber in any circumstances.

Coordination of Benefits

This Plan contains a Coordination of Benefits (COB) provision that prevents duplication of payments. Under this provision, if a Member is eligible for healthcare benefits under any other valid coverage, the combined benefit payments from all coverages cannot exceed 100% of the covered expenses. *Other valid coverage* means all other insurance policies, which may include Medicare, that provide payments for medical expenses.

If a Member is covered by both Medicare and this Plan and is not a retiree, special COB rules may apply. Contact one of our Presbyterian Customer Service Center representatives for more information.

If a Member is currently covered under COBRA provisions, coverage ceases at the beginning of the month in which the Member either becomes enrolled for any other valid coverage, or until the COBRA period expires, whichever occurs first.

The following rules determine order of benefit determination between this Plan and any other plan covering a Member not on COBRA continuation on whose behalf a claim is made:

- No COB Provision. If the other valid coverage does not include a COB provision, that coverage pays first, and this Plan pays secondary benefits.
- Participant/Dependent. If the Member who received care is covered as the participant under one plan/coverage and as a Dependent under another, the employee's coverage pays first. If the Member is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a Dependent of an active participant, then the order of benefit determination is:
    - Benefits of the plan of an active worker covering the Medicare beneficiary as a Dependent;
    - Medicare;
    - Benefits of the plan covering the Medicare beneficiary as the policyholder or as an active or retired participant.

If the Member has other valid coverage, please contact the other carrier's Customer Service department to determine if that coverage is primary or secondary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may or may not be subject to those provisions.

- Dependent Child/Parents Not Separated or Divorced. If the Member who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the other valid coverage does not follow the birthday rule, then the gender rule applies (that is, the male parent's coverage pays first).
- Child/Parents Separated or Divorced. If two or more plans cover a Member as a Dependent child of divorced or separated parents, benefits for the child follow these rules:
    - Court-Decreed Obligations. Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's healthcare expenses, the coverage of that parent pays first.
    - Custodial/Non-Custodial. The plan of the parent with custody of the child pays first. The plan of the spouse of the parent with custody of the child pays second. The plan of the parent not having custody of the child pays last.
    - Joint Custody. When a court decree specifies that the parents share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plans covering the child follow the order of benefit determination rules applicable to children whose parents are not separated or divorced.
- Active/Inactive Participant. If the Member who received care is covered as an active participant under one plan/coverage and as an inactive participant under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active participant under one plan/coverage and as the Dependent of the *same* but *inactive* participant under another, the coverage through active employment

pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

- Longer/Shorter Length of Coverage. When none of the above applies, the coverage in effect for the longest continuous period of time pays first. The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in the entity that pays, provides, or administers the plan's benefits or a change from one type of plan to another.

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 providing certain limited types of Coverage)
- Is not entitled to benefits under Medicare, and
- May not be claimed as a Dependent on another person's tax return

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

If you receive more than you should have when benefits are coordinated, you are required to repay any overpayment.

Your other valid coverage may be with a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or another program that limits or excludes benefits if you do not meet the obligations for obtaining **Prior Authorization** of care, for obtaining the proper level of care for the condition treated or for obtaining services from Providers authorized or recognized by your primary carrier. If you do not meet these obligations and your primary benefits are reduced as a result, Presbyterian Health Plan limits its secondary benefit payment to the difference between the Presbyterian Health Plan Negotiated Fee-for-Service for the service received and the amount that would have been paid if you had met the obligations recognized by your primary carrier.

Effect of Medicare on Benefits

Shortly before you or your spouse becomes age 65, or if you or any other family Member becomes qualified for Medicare benefits, contact your local Social Security office to establish Medicare eligibility. Then, contact your agency group representative to discuss coverage options.

If Medicare coverage coexists with this Plan, Medicare will be secondary until the Plan pays primary for at least 30 months from the date the Member became eligible for or entitled to Medicare on the basis of **end-stage renal disease**. A person Eligible under Medicare is defined as a Member or Dependent who is enrolled and covered under the voluntary portion (Part B) of Medicare, or who has been eligible to enroll under such part. All individuals who are eligible to enroll for Medicare Part B but have not done so, will be treated the same as all other persons

eligible under Medicare and **Presbyterian Health Plan will assume that eligible Members have Part B coverage. Plan benefits will be offset with Medicare** Part B benefits whether or not the Member actually receives them.

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.

Effect of Medicaid on Benefits

Benefits payable on behalf of a Member who is qualified for Medicaid will be paid to the Plan when:

- The Plan has paid or is paying benefits on behalf of the Member under the Group's Medicaid program pursuant to Title XIX of the Federal Social Security Act; and
- The payment for the services in question has been made by the Plan to the Medicaid Provider.

Benefits payable on behalf of a Member who is qualified for Medicaid is made to the New Mexico Health Care Authority or to the Medicaid Provider when required by law.

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.

Other valid coverage

All other insurance policies, including Medicare and other Medicare complementary or supplemental policies, both group and non-group (but **not** TriCARE, Medicaid, or Indian Health Service coverages, which are secondary to this Plan), that provide payments for medical services.

For a work-related injury or condition, see the "Work-related conditions" exclusion in Limitations and Exclusions Section. In accordance with Central New Mexico Community College, the coverage provided by this Plan is secondary to all other valid coverage to which the eligible CNM participant is entitled. CNM Plan is also secondary to any CNM dental or vision plan. (Contact CNM at **1-800-233-2576** for coordination of benefits information for prescription drug services.) When a Member is eligible for benefits under any other valid coverage, the combined benefit payments from all coverage cannot exceed 100% of the covered expenses.

Note: If you are eligible for Medicare Part B but have not enrolled, you will be responsible for the amount that Medicare Part B would have paid had you enrolled.

If a Member is currently covered under the continuation of coverage provision, coverage ceases at the beginning of the month in which the Member either reaches age 65 or first becomes eligible for any other valid coverage, unless a pre-existing condition limitation applies, or until the continuation of coverage period expires, whichever occurs first. If you receive more than you should have when benefits are coordinated, you are expected to repay any overpayment. Your other valid coverage may be with a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or another program that limits or excludes benefits if you do not meet the obligations for obtaining **Prior Authorization** of care, for obtaining the proper level of care for the condition treated, or for obtaining services from Providers authorized or recognized by your primary carrier. If you do not meet these obligations and your primary benefits are reduced as a result, this Plan will limit its secondary benefits payment to the difference between covered charges for the service received and the amount that would have been paid by your other coverage. (Admission review and prior approval requirements are waived under this Plan if this Plan is secondary to other coverage.) Primary benefit reductions are not eligible for payment under this Plan.

Responsibility for Timely Notice

Presbyterian Health Plan is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this Plan, Presbyterian Health Plan has the right to pay the other plan any amount Presbyterian Health Plan determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Plan, and with that payment Presbyterian Health Plan will fully satisfy its liability under this provision.

Right of Recovery

Regardless of who was paid, whenever benefit payments made by Presbyterian Health Plan exceed the amount necessary to satisfy the intent of this provision, Presbyterian Health Plan has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

Third-Party Liability Subrogation

Third-party liability exists when someone else is or may be legally responsible for your condition or injury. When a third party is liable for the costs of any Covered Service, CNM has subrogation rights. This means that CNM has the right, either as co-plaintiff or by direct suit, to enforce your claim against a third party for the benefits paid to you or on your behalf. If CNM provides benefits, CNM has a direct first-party priority lien against any money you may recover from a third party or any other source as a result of the condition or injury. CNM‘s lien must be

satisfied regardless of the amount you recover. If a third party is or may be liable for the cost of or charges for any Covered Services, the following actions must be taken:

- You must promptly notify Presbyterian Health Plan and CNM of the claim against the third party.
- If you receive money for the claim by suit, settlement, or otherwise, you or your attorney must reimburse CNM for the amount of benefits provided under this Plan or an amount agreed upon with CNM. You may not exclude recovery for CNM healthcare benefits from any type of damages or settlement recovered.

You must cooperate in every way necessary to help CNM enforce its subrogation rights. You may not take any action that might prejudice CNM's subrogation rights. When you fail to cooperate in satisfying CNM's subrogation interest and CNM must file a lawsuit against you or the third party in order to enforce its rights under this provision, you or any of your Dependents receiving benefits under this Plan will be responsible for attorneys' fees and costs incurred by Presbyterian Health Plan and CNM.

Subrogation

When this Plan pays for your care and you have the right to recover those expenses from the person or organization causing your illness or Accidental Injury, Presbyterian Health Plan has the right of subrogation to recover the amount it has paid. This right of subrogation against the third party may be exercised even if you do not file a legal action. The right of subrogation applies whether you recover directly from the wrongdoer or from the wrongdoer's insurer, or from your uninsured motorist insurance coverage. This applies to any and all moneys a Member may receive from any third party or insurer, or from any uninsured or underinsured motorist insurance benefits, as well as from any other person, organization or entity.

You have the legal obligation to help recover the amounts paid, and you must do nothing that would prejudice Presbyterian Health Plan's subrogation right. You must notify Presbyterian Health Plan if you file a claim, consult an attorney, or bring action against a third party. If contacted by Presbyterian Health Plan, you must provide all requested information. Settlement of a controversy without prior notice to Presbyterian Health Plan is a breach of this agreement. In the event that you fail to cooperate with Presbyterian Health Plan or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of Presbyterian Health Plan, Presbyterian Health Plan may recover its benefit payments from you.

Assignment of Benefits

Your benefits under the Plan generally cannot be transferred or assigned in any way, except as required under a Qualified Medical Child Support Order (QMCSO). A qualified child support order is a court order that may be granted in the case of a divorce.

Fraudulent Application or Claim

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

Grievance Procedures

Overview

Many Grievances or problems can be handled informally by calling the Presbyterian Customer Service Center (PCSC) at **(505) 923-7752** or **1-866-670-0600 (TTY 711)**. You can also visit our website at **www.phs.org**.

Presbyterian Health Plan (PHP) has established written procedures for reviewing and resolving your Grievances and concerns. There are two different procedures, depending on the type of Grievance: Adverse Determination Grievance procedures and Administrative Grievance procedures.

Types of Grievances

- **Adverse Determination Grievance** – An Adverse Determination Grievance is an oral or written complaint submitted by or on behalf of a covered person regarding an Adverse Determination.
    - Adverse Determination means a decision made by PHP (either pre-service or post-service) that a healthcare service requested by a Provider or covered person has been reviews and, based upon the information available, does not meet PHP's requirements for coverage or medical necessity, and the requested healthcare service is denied, reduced or terminated.

- **Administrative Grievance** – An Administrative Grievance is an oral or written complaint submitted by or on behalf of a covered person 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 affect the availability, delivery or quality of healthcare services
    - Claims payment, handling or reimbursement for healthcare services
    - Termination of Coverage

Any Grievance may be submitted orally or in writing. If you make an oral Grievance, PCSC will assist you to complete the required forms. Please be advised that PHP shall not take any retaliatory action against you for filing a Complaint.

You must request a copy and detailed written explanation of the Grievance procedures by calling PCSC at **(505) 923-7752** or **1-866-670-0600 (TTY 711).**

Participants have **180 days** from the date of the initial denial to file an appeal with us.

Adverse Determination Grievance Review Procedures

When you or your treating healthcare professional requests a healthcare service, PHP shall initially determine whether the requested healthcare service is Covered by your health plan and is Medically Necessary within **24 hours** where circumstances require expedited review and **five working days** for all other cases. If PHP's initial review results in the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the determination and of your right to request an internal review by PHP.

You may request an internal review orally or in writing by contacting:

Address: Presbyterian Health Plan
Attn: Appeals and Grievance Department
PO Box 26267 Albuquerque, NM 87125-6267
Phone: (505) 923-7752 or **1-866-670-0600 (TTY 711)**
Fax: (505) 923-5124
Email: gappeals@phs.org

PHP's internal Adverse Determination Appeal review procedures require an initial review by a PHP medical director. and then, if necessary, a second review by a medical panel. Both reviews must be completed within **72 hours** when the circumstances require expedited review or within **30 calendar days** for all other cases. If PHP's medical director decides to uphold the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the medical director's decision by phone and mail and will ask you whether you want a second review by a medical panel selected by the healthcare insurer.

If you indicate that you want a second review of your Appeal by a medical panel, then PHP will notify you of the date, time and location of the medical panel review and of your rights to participate in the review.

Administrative Grievance Procedures

If you are dissatisfied with a decision, action or inaction of PHP regarding a matter that does not involve the denial, reduction or termination of a requested health service, then you have the right to request, orally or in writing, that PHP internally review the matter. First, a PHP representative will review the Grievance and provide you with a written decision within **60 calendar** days from receipt of the Grievance.

If you are dissatisfied with this decision, you may file a request for reconsideration by PHP. Presbyterian Health Plan will appoint a reconsideration committee to review the Grievance and will schedule a hearing. Presbyterian Health Plan will notify you of the date, time and location of the hearing and of your rights in the process. Presbyterian Health Plan will mail you a written decision within **seven working days** after the hearing.

CNM Grievance Review Procedures

If the grievant is not satisfied with PHP's decision under either category above, they may appeal the decision by filing a formal complaint to the Authority within **30 days** of the day the Grievance decision was made. (**Note:** You may contact CNM at any time during the Grievance process.) Upon receipt of the appeal request, the Authority will review the case and respond to the parties involved within **30 days**.

Central New Mexico Community College (CNM)
Director of Benefits
525 Buena Vista Drive SE
TM 104
Albuquerque, New Mexico 87106
(505) 224-4600

External Review of a Denied Appeal

If the appeal to your health plan is denied, you may file a request for external reviews of your appeal by an Independent Review Organization (IRO). An IRO is an Independent Review Organization, external to PHS and your health plan that utilizes independent physicians with appropriate expertise to perform the review of external reviews. This includes determining if surprise billing protections are applicable. In rendering a decision, the IRO may consider any appropriate additional information submitted by you and will follow the plan documents governing your benefits.

There are no fees or costs imposed on you for the external review of your appeal. The decision has rights to any other benefits under the Employees' Health Plan (EHP). You are not required to undergo an external review of your appeal before pursuing legal action.

When your appeal is denied by the health plan, you will receive a letter that describes the process to follow if you wish to pursue an external review of your appeal through an IRO.

If you choose to file a request for external review of your appeal with an IRO:

- You may do so only after exhaustion of the required appeal to your health plan. Accordingly, you must first submit an appeal with your health plan and receive a denial of your appeal before requesting a voluntary appeal.

- After you receive a denial of your appeal, you must submit the request for external review of your appeal with your health plan in writing within **four months** for the date of the appeal denial letter from your health plan.
- The health plan will forward a copy of the final appeal denial letter and all other pertinent information that was reviewed in the appeal in to the IRO. You may also submit additional information you with so be considered.
- You will be notified of the decision of the IRO within **45 days** of the receipt of the request for the external review of your appeal.
- The statute of limitations or other defense based on timeliness is suspended during the time that an external review of your appeal is pending.

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

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

If you choose not to submit a request for external review of your appeal:
The EHP waives any right to assert that you have failed to exhaust administrative remedies.

Retaliatory Action

Presbyterian Health Plan cannot take any retaliatory action against you for filing a Grievance under this health plan.

Member Rights And Responsibilities

Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your health plan. Above all, your relationship with your Provider/Practitioner is essential to good health. We encourage open communication between you and your Provider/Practitioner. Member Rights and Responsibilities regarding your health insurance can be found at **https://www.phs.org/member-rights** or by calling the Presbyterian Customer Service Center at **(505) 923-7752** or toll-free at **1-866-670-0600**.

Glossary of Terms

ACCIDENTAL INJURY means a bodily injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia, or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an Accidental Injury.

ACUPUNCTURE means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

ADMISSION means the period of time between the date a patient enters a Hospital or other facility as an Inpatient and the date they are discharged as an Inpatient. The date of Admission is the date of service for the hospitalization and all related services. Admission starts when a provider writes an order for an Inpatient stay and ends when the provider write the discharge order.

ALCOHOLISM means alcohol dependence or alcohol use disorder meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

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

AMBULATORY SURGICAL FACILITY means an appropriately licensed provider, with an organized staff of Provider that meets all of the following criteria:

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

ANNUAL OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received during a benefit period that is the Member's responsibility.

APPEAL means a request from a Member, or their representative; or a Provider for reconsideration of an adverse organizational determination (denial, reduction, suspension or termination of a benefit).

APPLICATION means the form that a participant is required to complete when enrolling for Presbyterian Health Plan coverage.

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

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 specific; Rett's Disorder; and Childhood Disintegrative Disorder.

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

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received during a benefit period that is the Member's responsibility.

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

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

CO-DEPENDENCY means behaviors learned by family Members or significant others in order to survive in an environment of great emotional pain and stress when a family Member is dependent upon the use of alcohol or drugs.

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

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

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

COSMETIC SURGERY means Surgery that is performed to reshape normal structures of the body in order to improve appearance and self-esteem.

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

CUSTODIAL CARE means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

CUSTOM-FABRICATED ORTHOSIS means an Orthosis, 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.

DEDUCTIBLE means the amount that must be paid for by you each Calendar Year toward Covered Services **before** health benefits for that Member will be paid by the Plan (except for those services requiring only a Copayment).

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

DEPENDENT means any Member of a covered participant's family who meets the requirements of the **Eligibility, Enrollment, and Effective Dates Section**, of this *Member Benefit Booklet* and is actually enrolled in the Plan.

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

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

EMERGENCY MEDICAL CONDITION means a medical condition which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to your health, if pregnant the health of you or your unborn child
- Serious impairment to the bodily functions, or
- Serious dysfunction of any bodily organ or part

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

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

FREESTANDING DIALYSIS FACILITY means a Provider primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home basis.

FREESTANDING HEALTHCARE FACILITIES are those that are stand alone and deliver many diagnostic and therapeutic services formerly provided only in hospitals.

GENETIC INBORN ERRORS OF METABOLISM (IEM) means a rare, inherited disorder that is present at birth, results in death or mental retardation if untreated, and requires consumption of Special Medical Foods. Categories of IEMs are as follows:

- Disorders of protein metabolism (i.e., amino acidopathies such as PKU, organic acidopathies, and urea cycle defects)
- Disorders of carbohydrate metabolism (i.e., carbohydrate intolerance disorders, glycogen storage disorders, disorders of gluconeogenesis and glycogenolysis), or
- Disorders of fat metabolism

GRIEVANCE means an oral or written complaint submitted by or on behalf of a covered person regarding the:

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

GROUP means a bona fide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

HEALTHCARE PROFESSIONAL means a Provider or other healthcare practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Healthcare Services consistent with state law.

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

HEALTH SAVINGS ACCOUNT means a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan. The funds contributed to an account are not subject to federal income tax at the time of deposit.

HOME HEALTH AGENCY means an appropriately licensed Provider that both:

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

HOSPICE means a duly licensed program or facility providing care and support to Terminally Ill Patients and their families.

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

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

IDENTIFICATION CARD or **ID CARD** means the card issued to the covered participant enrolled under this Plan.

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

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

INDEPENDENT CLINICAL LABORATORY means a laboratory that performs clinical procedures under the supervision of a Provider and that is not affiliated or associated with a Hospital, Provider, or Other Provider.

IN-NETWORK PROVIDER means Provider, Hospitals, and other Healthcare Professionals, facilities, and suppliers that have contracted with Presbyterian Health Plan as In-network Providers.

INPATIENT means a Member who has been admitted by a healthcare Provider/Practitioner to a Hospital for occupancy for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for which there is a room and board charge, and which are covered as defined in this Plan. Admissions are considered Inpatient based on medical necessity as identified in the Presbyterian Health Plan designated level of care criteria, regardless of the length of time spent

in the Hospital. Inpatient Admission begins when an order is written by a provider and ends with a discharge order from the Provider.

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

LICENSED MASSAGE THERAPIST means a person who is licensed by the appropriate state authority as a Licensed Massage Therapist or LMT. Certification alone does not meet the licensure requirement.

LICENSED LAY MIDWIFE means a person licensed by the state in which services are rendered to provide Healthcare Services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

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

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

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

MEDICAID means Title XIX of the Social Security Act and all amendments thereto.

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

MEDICALLY NECESSARY means a service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under the Plan, and is determined by Presbyterian Health Plan's medical director to meet all of the following conditions:

- It is medical in nature
- It is recommended by the treating Provider
- It is the most appropriate supply or level of service, taking into consideration:
    - Potential benefits
    - Potential harms
    - Cost, when choosing between alternatives that are equally effective
    - Cost-effectiveness, when compared to the alternative services or supplies
- It is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established

services or supplies, professional standards and expert opinion may also be taken into account)
- It is not for the convenience of the Member, the treating Provider, the Hospital, or any other healthcare Provider

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

MEDICARE ALLOWABLE means a fee schedule with a complete listing of fees used by Medicare to pay doctors, hospitals, or other Providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a Provider and/or other Providers for services rendered on a fee-for-service basis. CMS develops fee schedules for Providers, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

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

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

MEMBER BENEFIT BOOKLET (MBB) means this booklet.

MENTAL HEALTH means the absence of behavioral illness. Individuals are considered mentally healthy if they are comfortable with their life situation and their behavior does not conflict with their associates or the rest of society.

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

OBSERVATION means those furnished by a Hospital and Provider/Practitioner on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible Admission to the Hospital as an Inpatient, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under Outpatient Observation stay, it is on the Provider's/Practitioner's written order. If not formally admitted as an Inpatient, the patient initially is treated as an Outpatient. The Member must meet the Presbyterian Health Plan designed level of care criteria to be considered an inpatient admission. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

OCCUPATIONAL THERAPIST means a person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction, caused by

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

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

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

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

OUT-OF-NETWORK PROVIDER means a duly licensed healthcare Provider, including a medical facility, which has no agreement with Presbyterian Health Plan for reimbursement of services to Members.

OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received in a Calendar Year that is the Member's responsibility, which is determined by the benefit level for the services received. It **does not include** expenses in excess of negotiated fees,

Medicare Allowable Amounts, prescription drug Copayments, non-covered expenses, and specifically excluded expenses and services. The Out-of-network, Out-of-pocket expenses do **not** accrue toward the Out-of-pocket Maximum and vice versa.

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

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

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

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

PRESBYTERIAN HEALTH PLAN, INC. means Presbyterian Health Plan, a corporation organized under the laws of the State of New Mexico.

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

PRESCRIPTION DRUGS means those drugs that, by Federal law, require a Physician's prescription for purchase.

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

PROSTHESIS, PROSTHETIC DEVICE means an externally attached or surgically implanted artificial substitute for an absent body part, for example, an artificial eye or limb.

PROVIDER means a duly licensed Hospital, duly licensed practitioner of the health arts acting within the scope of their license, or Other Provider performing within the scope of the appropriate licensure.

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

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

REGISTERED LAY MIDWIFE means a person licensed by the state in which services are rendered to provide Healthcare Services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

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

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

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

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

SERVICE AREA means the entire state of New Mexico.

SKILLED NURSING CARE means services that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse or Registered Nurse.

SKILLED NURSING FACILITY means an institution that is licensed under state law to provide Skilled Nursing Care services.

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

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

SPECIAL MEDICAL FOODS means nutritional substances in any form that are:

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

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

STATUTORY MINIMUM HDHP DEDUCTIBLE means the minimum Deductible that a health plan must have to be a CNM High Deductible Health Plan under Internal Revenue Code Section 223. To be eligible for HSA contributions, an individual must have HDHP coverage and no other health plan coverage (with very few exceptions) up to the Statutory Minimum HDHP Deductible for the current year.

SUMMARY PLAN DESCRIPTION (SPD) means this booklet.

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, and
- Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer

SURGERY means the performance of generally accepted operative and cutting procedures, including:

- Specialized instrumentation, endoscopic examinations, and other invasive procedures
- Correction of fractures and dislocations, and
- Usual and related preoperative and postoperative care

TEFRA means Federal law regarding the working aged.

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

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

TOTAL ALLOWABLE CHARGES means, for In-network Providers, the Total Allowable Charges may not exceed the amount the In-network Provider has agreed to accept from Presbyterian Health Plan for a service. For Out-of-network Providers, the Total Allowable Charges may not exceed the **Reasonable and Customary Charge** as determined by Presbyterian Health Plan for a service.

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

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

VIDEO VISIT means an online consultation between a designated Practitioner/Provider and a patient about non-urgent healthcare matters.

WELL-CHILD CARE means routine pediatric care through the age of 72 months, and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

Notice of Privacy Practices

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

This Notice is effective as of April 14, 2003, and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the Central New Mexico Community College (the "Plan") creates or receives about you. You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your Protected Health Information or PHI). This Notice is intended to inform you about how the Plan will use or disclose your PHI; your privacy rights with respect to the PHI; the Plan's duties with respect to your PHI; your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services (HHS); and the office to contact for further information about the Plan's privacy practices.

How the Plan Will Use of Disclose Your PHI

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

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

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

The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages; disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness; disclosures to determine if the claim for benefits are Covered under the Plan; are Medically Necessary Experimental, or Investigational; and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above.

For the Plan's Operations. Your PHI may be used as part of the Plan's healthcare operations. Healthcare operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of healthcare Providers and conducting cost management and quality improvement activities, and customer service and resolution of internal Grievances.

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family Members, other relatives and your close personal friends if**:**

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You either have agreed to the disclosure or have been given an opportunity to object and have not objected.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted/preferred service Providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against Providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive,

material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Your Privacy Rights With Respect to PHI

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or healthcare operations, or to restrict uses and disclosures to family Members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a designated record set, for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions

or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your Mental Health professional during a counseling session. Psychotherapy notes do not include summary information about your Mental Health treatment.

A designated record set includes the medical records and billing records about individuals maintained by or for a covered healthcare Provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. **You must make requests for amendments in writing and provide a reason to support your requested amendment**.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or healthcare operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Receive Confidential Communications

You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information Section below.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of their authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for healthcare purposes, notarized by a notary public
- A court order of appointment of the person as the conservator or guardian of the individual, or
- An individual who is the parent of a minor child

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties With Respect to Your PHI

The Plan has the following duties with respect to your PHI:

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

Your Right to File a Complaint

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

Contact Information

If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact Central New Mexico Community College.

Acceptance Page

Central New Mexico Community College (CNM) agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the Central New Mexico Community College (CNM) HDHP Medical Plan.

By: Date:

_____ _____

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Presbyterian Healthcare Services does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Presbyterian Customer Service Center at **(505) 923-5420, 1-855-592-7737, TTY 711**.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by phone, mail, fax, or email at:

Mailing Address: Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone/TTY: **1-866-977-3021**, **TTY 711**

Fax: **(505) 923-5124**

Email: **info@phs.org**

If you need help filing a grievance, the Presbyterian Privacy Officer and Civil Rights Coordinator is available to help you.

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

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

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

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

This notice is available at Presbyterian Healthcare Services website: **www.phs.org/nondiscrimination**.

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Notice of Availability

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.
Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.
Navajo Diné	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-855-592-7737 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
Vietnamese Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-592-7737 (Người khuyết tật: TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
German Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-592-7737 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
Chinese Simplified 简体中文	注意：如果您使用简体中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以提供无障碍格式版信息。请拨打 1-855-592-7737 (TTY: 711) 或咨询您的服务提供者。
Chinese Traditional 繁體中文	注意：如果您使用繁體中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務，以提供無障礙格式版資訊。請致電 1-855-592-7737 (TTY:711) 或諮詢您的服務提供者。
Japanese 日本語	注:日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-592-7737(TTY:711)までお電話ください。または、ご利用の事業者にご相談ください。
Filipino	ATTENTION: Kung marunong kang magsalita ng Filipino, makakagamit ka ng mga libreng serbisyo sa tulong sa wika. Ang mga angkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Korean 한국어	주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-855-592-7737(TTY: 711)로 전화하거나 서비스 제공업체에 문의하세요.

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French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-592-7737 (TTY: 711) или обратитесь к своему поставщику услуг.
Urdu اردو	توجہ دیں: اگر آپ اردو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ 1-855-592-7737 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. ومتاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم 1-855-592-7737 (TTY: 711) (خدمة الهاتف النصي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DİKKATİNİZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.