PRESBYTERIAN

TriCore Reference Labs

Summary Plan Description and Guide to Your High Deductible Health Plan (HDHP) (PPO) Plan

Presbyterian Health Plan, Inc.

Group HDHP PPO Benefit Plans

HWP20034

Underwritten by Presbyterian Health Plan

TRICORE HDHP
MPC012616

01/01/2026

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

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

Phone:
(505) 923-5258 or
1-866-979-6778
TTY: 711

Prior Authorization

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

Phone:
(505) 923-5258 or
1-866-979-6778

Claims

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

Phone:
(505) 923-5258 or
1-866-979-6778

Appeals and Grievances

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

Phone:
(505) 923-5258 or
1-866-979-6778

Website

www.phs.org

Table of Contents

Summary of Benefits

The following are the Highlights of the TriCore High Deductible Health Plan (HDHP) administered by Presbyterian Health Plan, Inc., (PHP) for TriCore employees. These benefits are effective 1/1/26 through 12/31/26. The specific terms of coverage, limitations and exclusions are detailed in Sections 2, 4, and 5 of the Summary Plan Description.

TRICORE HDHP PLAN (HWP20034)		
Benefit Highlights	**In-Network Care**	**Out-of-Network**
Member deductible (Calendar Year) Single Family	 Single $3,400 Family $6,800	 Single $5,000 Family $10,000
Out-of-Pocket Maximum (Contract Year) Includes medical and Rx cost-sharing Single Family	 Single $5,000 Family $10,000	 Single $6,350 Family $12,700
Lifetime maximum Unlimited (Certain services are subject to Contract Year and/or lifetime maximums or are limited per condition).		
Copayments/Coinsurance vary depending on service; see below		
BENEFITS AND COVERAGE	**In-network Coinsurance**	**Out-of-network Coinsurance**
PROVIDER SERVICES Including: • Office visits • Primary Care Provider • Specialist • Home visits if Medically Necessary • Outpatient surgery (in Provider's office) • Medical Drugs (1) (injectable forms administered in Provider's office) • Allergy Services o Testing o Serum (extracts) • Injections such as insulin, • heparin and injectable antibiotics	30% after Deductible	50% after Deductible(3)
• Video Visits • Allergy Injections	No charge after Deductible	50% after Deductible(3)

Prior Authorization may be required(1) Not subject to Deductible(2) You are responsible for any balance due above Reasonable and Customary Charges(3) 20% penalty applies if Prior Authorization is not obtained(4)Refer to the Summary Plan Description for a more complete description of benefits.

TRICORE HDHP (HWP20034) BENEFITS AND COVERAGE	In-network Coinsurance	Out-of-network Coinsurance
PROVIDER SERVICES *(continued from previous page)*		
Preventive Services • Routine physicals • Well-child Care including vision and hearing screening (through age 26) • Immunizations • Adult Wellness • Health education programs	No charge after Deductible	50% after Deductible[3]
Women's Preventive Services • Contraceptive Methods o Intrauterine Devices (IUD) o Hormone Contraceptive Injections o Inserted Contraceptive Devices o Implanted Contraceptive Devices	No charge after Deductible	50% after Deductible[3]
Breastfeeding support, supplies and counseling (for one year after delivery)	No charge after Deductible	50% after Deductible[3]
HOSPITAL SERVICES – Inpatient [1] Coverage includes: • Room and Board • Newborn delivery and other Hospital Obstetrical (OB) services • In-Hospital Provider visits, Surgeons, Anesthesiologist and other Inpatient services • Detoxification • Newborn care if discharged and re-admitted	30% after Deductible	50% after Deductible[3]

Prior Authorization may be required[1] Not subject to Deductible[2] You are responsible for any balance due above Reasonable and Customary Charges[3] 20% penalty applies if Prior Authorization is not obtained[4] Refer to the Summary Plan Description for a more complete description of benefits.

TRICORE HDHP (HWP20034) BENEFITS AND COVERAGE	In-network Coinsurance	Out-of-network Coinsurance
MEDICAL SERVICES – Outpatient • Surgeries [(1)] (at facility) • Bariatric surgery [(1)], when Medically Necessary • X-ray and laboratory tests • PET [(1)]/CAT [(1)]/MRI [(1)] scans • Cardiac cath/ GI lab • Radiation therapy (non-surgical) • Chemotherapy • Medical Drugs [(1)] Oral or inhalation forms/self-administered • Medical Drugs [(1)] • Intravenous (IV) • Sleep Studies o Home o Outpatient • Administration of blood/blood components	30% after Deductible	50% after Deductible*(3)*
RECONSTRUCTIVE SURGERY [(1)]	30% after Deductible	50% after Deductible*(3)*
EMERGENCY ROOM CARE Including trauma services	30% after Deductible	30% after Deductible
URGENT CARE	30% after Deductible	30% after Deductible
AMBULANCE SERVICES- Including: Emergency or high-risk • Ground ambulance • Air ambulance Inter-facility transfer services • Ground ambulance • Air ambulance	30% after Deductible	30% after Deductible
WOMEN'S HEALTHCARE • Gynecological care • In-office Obstetrical/Maternity Care • Prenatal and Postnatal care • Specialist (i.e., Perinatologist) • Newborn Delivery and other Hospital Obstetrical (OB) services	30% after Deductible	50% after Deductible*(3)*

Prior Authorization may be required(1) Not subject to Deductible(2) You are responsible for any balance due above Reasonable and Customary Charges(3) 20% penalty applies if Prior Authorization is not obtained(4) Refer to the Summary Plan Description for a more complete description of benefits

TRICORE HDHP (HWP20034) BENEFITS AND COVERAGE	In-network Coinsurance	Out-of-network Coinsurance
DIABETES SERVICES • Office visit and diabetes education • Diabetic supplies or External Prosthetic Appliances (1) (Purchased through a Durable Medical Equipment supplier)	30% after Deductible	50% after Deductible(3)
COVERED MEDICATIONS • Medical Drugs (1) Oral or inhalation forms/self-administered • Medical Drugs (1) Intravenous (IV)	30% after Deductible	50% after Deductible(3)
PRESCRIPTION DRUGS • Generic • Preferred Brand • Non-Preferred • Specialty (Not available for mail order)	Retail: 30% after Deductible Mail Order: 30% after Deductible Retail: 30% after Deductible	**Not Covered** **Not Covered**
MENTAL HEALTH SERVICES (1) • Outpatient • Inpatient • Partial Hospitalization	30% after Deductible	50% after Deductible(3)
ALCOHOL AND SUBSTANCE USE DISORDER SERVICES (1) Detoxification • Outpatient • Inpatient Rehabilitation • Outpatient • Inpatient/Partial Hospitalization	30% after Deductible	50% after Deductible(3)

Prior Authorization may be required(1) Not subject to Deductible(2) You are responsible for any balance due above Reasonable and Customary Charges(3) 20% penalty applies if Prior Authorization is not obtained(4) Refer to the Summary Plan Description for a more complete description of benefits.

TRICORE HDHP (HWP20034) BENEFITS AND COVERAGE	In-network Coinsurance	Out-of-network Coinsurance
REHABILITATION AND THERAPY SERVICES • Cardiac Rehabilitation • Dialysis/Plasmapheresis/Photopheresis • Pulmonary Rehabilitation	30% after Deductible	50% after Deductible[3]
SHORT-TERM REHABILITATION [1] Physical Therapy • Inpatient • Outpatient Occupational Therapy • Inpatient • Outpatient • Speech and Hearing therapy	30% after Deductible	50% after Deductible[3]
TRANSPLANTS [1]	30% after Deductible	50% after Deductible[3]
COMPLEMENTARY THERAPIES[5] (Limited) • Acupuncture services (up to 20 visits per Calendar Year if Medically Necessary) • Chiropractic services (up to 20 visits per Calendar Year if Medically Necessary) • Biofeedback for specific conditions	30% after Deductible	50% after Deductible[3]
SKILLED NURSING FACILITY[1] (Up to 60 days per Calendar Year)[5]	30% after Deductible	50% after Deductible[3]
HOME HEALTHCARE SERVICES [1] **HOME INTRAVENOUS SERVICES** [1] • Services provided by an RN, LPN and other specified specialist • Home intravenous services and supplies • Medical Drugs [1] Oral or inhalation forms/self-Administered • Medical Drugs [1] Intravenous (IV)	30% after Deductible	50% after Deductible[3]

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

Refer to the Summary Plan Description for a more complete description of benefits.

TRICORE HDHP (HWP20034) BENEFITS AND COVERAGE	In-network Coinsurance	Out-of-network Coinsurance
HOSPICE CARE [(1)] • Inpatient • In home	30% after Deductible	50% after Deductible[(3)]
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[(1)] Hearing Aids (for school-aged children under age 18 or 21 years of age if still attending high school).	30% after Deductible Plan pays $2,200 Every 36 months per hearing-impaired ear.	50% after Deductible[(3)] Plan pays $2,200 Every 36 months per hearing-impaired ear.
EYEGLASSES AND CONTACT LENSES[(1)] Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus, or when related to Genetic Inborn Errors of Metabolism • Refraction eye exam associated with post-cataract surgery or Keratoconus correction	30% after Deductible	50% after Deductible
DENTAL SERVICES/ (CMJ/TMJ) (Limited)	30% after Deductible	50% after Deductible
FAMILY, INFANT AND TODDLER PROGRAM Family, Infant and Toddler Program (FIT): Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Healthcare Services	No Copayment $3,500 per Participant per Plan Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits.	Not Covered

Prior Authorization may be required[(1)] Not subject to Deductible[(2)] You are responsible for any balance due above Reasonable and Customary Charges[(3)] 20% penalty applies if Prior Authorization is not obtained[(4)] Refer to the Summary Plan Description for a more complete description of benefits.

Health Management

- Presbyterian Health Plan 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 – **(505) 923-5570 or 1-866-221-9679**.
- Help with managing chronic conditions through Presbyterian Healthy Solutions Department – **(505) 923-5487** or **1-800-841-9705**.
- Useful online WebMD Health Manager site featuring up-to-date health information and resources to help create a personalized health improvement – **https://www.phs.org/tools-resources/patient/recommended-health-resources**.
- Useful diabetes education and support through our Certified Diabetes Educators. These resources are available through "Find a Doctor" on **https://www2.phs.org/php_directory?insurance_plans=AHPH**.

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

Welcome

Welcome to Presbyterian Health Plan!

This Summary Plan Description (SPD) describes your group medical benefits. TriCore offers this Preferred Provider Organization (PPO) Plan, hereafter referred to as the "Plan" or "Agreement." We are a Healthcare Insurer operated as a division of Presbyterian Healthcare Services, a locally owned New Mexico healthcare system. When we use the words "Presbyterian Health Plan," "PHP," "we," "us," and "our" in this document, we are referring to Presbyterian Health Plan. When we use the words "you" and "your," we are referring to each Member.

This SPD is intended to provide you with easy-to-understand general explanations of the more significant provisions of your Plan effective January 1, 2025. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this SPD and the Claims administrative procedures of our Third-Party Claim Administrator, Presbyterian Health Plan, or if any provision is not covered or only partially covered, the terms of this SPD will govern in all cases.

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

Information you will find in this *Summary Plan Description* includes:

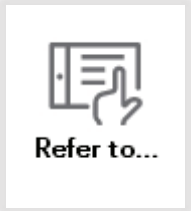
- Your rights and responsibilities as a Member
- Covered Benefits available through this plan
- How to access services from Providers and Pharmacies
- Services that require **Prior Authorizati**on
- **Limitations and Exclusions** for certain Covered Benefits
- Coverage for your Dependents who are outside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

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

Please take time to read this *Summary Plan Description* and *Summary of Benefits and Coverage*, including **Benefits, Limitations, and Exclusions**. Understanding how this plan works can help you make the best use of your Covered Benefits. You should keep this *Summary Plan Description,* your *Summary of Benefits and Coverage*, and any other attachments or Endorsements you may receive for future reference.

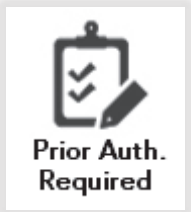
Understanding This Summary Plan Description

We use visual symbols throughout this Summary Plan Description (SPD) 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:

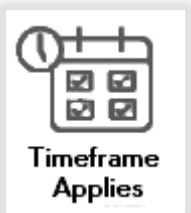


Refer To – This "Refer To" symbol will direct you to read related information in other sections of the SPD or *Summary of Benefits and Coverage* when necessary. The Section being referenced will be bolded.

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.

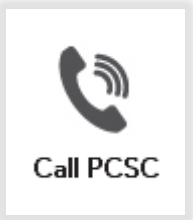


Prior Authorization Required – This "**Prior Authorization**" symbol will appear next to those Covered Benefits that require our Authorization (approval) in advance of those services. To receive full benefits, your In-network Practitioner/Provider must call us and obtain Authorization before you receive 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 should call as soon as possible.



Timeframe Requirement – This "Timeframe" symbol appears to remind you when you must take action within a certain time frame 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.



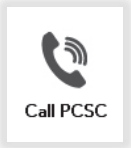
Call Presbyterian Customer Service Center – This "Call PCSC" symbol appears whenever we refer to our Presbyterian Customer Service Center or to remind you to call us for information.

In addition, some important terms used throughout this Summary 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) 923-5258** or **1-866-979-6778**. 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

This booklet is your *Summary Plan Description (SPD)*. 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 Providers, Hospitals, and other Healthcare Professionals or facilities that provide Healthcare Services.
- In-network Providers have contractual agreements with Presbyterian Health Plan, Inc. (PHP) and allow lower out-of-pocket expenses and additional benefits for covered persons.
- Out-of-network Providers do not have contractual agreements with PHP, which may increase the out-of-pocket expenses and limit benefits for covered persons.

This 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 an In-network Provider**. TriCore generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

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, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5258** (in Albuquerque), or toll-free at **1-866-979-6778**. TTY users may call **711**. It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

Member Rights and Responsibilities

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

As a Member of PHP, you have specific rights and certain responsibilities.

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

Member Rights

All Members have a right to:

- Be treated with courtesy, consideration, respect, and recognition of their dignity
- Have their privacy respected, including the privacy of medical and financial records maintained by the Claim Administrator and its healthcare Providers as required by law
- Be advised of the Claim Administrator's policies and procedures regarding products, services, Providers, and Appeals procedures, including detailed benefit information, and Member rights and responsibilities
- Request and obtain information about any financial arrangements between the Claim Administrator and its Providers which might restrict referral or treatment options, or limit services offered to Members
- Be told the details about what is covered, maximum benefits, what is not covered, what drugs or medicines are restricted, and how to obtain **Prior Authorizations**, when needed
- Receive affordable healthcare, with limits on out-of-pocket expenses
- Seek care from a Non-Participating Provider and be advised of their financial responsibility if they receive services from a Non-Participating Provider or receive services without required **Prior Authorization**
- Be notified promptly of termination, decreases or changes in benefits, services, or the Provider network
- Participate with Providers in decision making regarding their healthcare
- Clear and candid discussion of Medically Necessary treatment options, regardless of benefit coverage or cost
- Refuse care, treatment, or medications after the Practitioner has explained the care, treatment or other advice in language the Member understands
- Refuse the care of a specific Practitioner
- Be informed of the potential consequences of such refusal as outlined in this booklet
- Have adequate access to qualified health professionals near where they live or work
- Receive information from their Provider, in terms that they understand, including an explanation of their complete medical condition, recommended treatment, risk(s) of the

treatment, expected results and reasonable medical alternatives irrespective of the Claim Administrator's position on treatment options
- Have the explanation provided to next of kin, guardian, agent or surrogate if available, when the Member is unable to understand
- Have all explanations to the next of kin, guardian, agent or surrogate recorded in the Member's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Member
- Have access to services when Medically Necessary, as determined by their primary or treating Provider, in consultation with the Claim Administrator, **24 hours** per day, **seven days** a week for urgent or Emergency Care services, and for other health services as defined by this booklet
- Have access to translator services for Members who do not speak English as their first language, and translation services for hearing-impaired Members for communication with the Claim Administrator
- Receive a complete explanation of why services or benefits are denied, a chance to appeal the decision to the Claim Administrator and to receive an answer within a reasonable time
- Receive a Certificate of Creditable coverage when a Member's enrollment in this Plan terminates
- Make complaints or Appeals regarding the Claim Administrator or the care provided
- Continue an ongoing course of treatment for a period of at least **30 days** if the Member's Provider leaves the Provider network or if a new Member's Provider is not in the Provider network

Member Responsibilities

All Members must:

Review this booklet and if there are questions, call the PCSC, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5258** (in Albuquerque), or toll-free within New Mexico at **1-866-979-6778** for clarification of benefits, limitations, and exclusions outlined in this booklet. TTY users may call **711**.

- Provide, as much as possible, information that the Claim Administrator and Providers need in order to provide services or care or to oversee the quality of such care or services.
- Follow the Claim Administrator's policies, procedures, and instructions for obtaining services and care.
- Follow the plans and instructions for care that they have agreed upon with their Provider.
- Follow any instructions and guidelines given by a Provider. A Member may, for personal reasons, refuse to accept treatment recommended by Providers. A Participating Provider may regard such refusal as incompatible with the continuance of the Provider-patient relationship and as obstructing the provision of proper Medical Care.
- Notify the Claim Administrator immediately of any loss or theft of their Identification Card.
- Refuse to allow any other person to use their Identification Card.

- Advise a Participating Provider of coverage with the Claim Administrator at the time of service. Members may be required to pay for services if they do not inform their Participating Provider of their coverage.
- Pay all required Copayments, Deductibles, and/or Coinsurance at the time services are rendered.
- Be responsible for the payment of all services obtained prior to the effective date of this Plan and subsequent to its termination or cancellation.
- Promise that all information given to the Claim Administrator in Applications for enrollment, questionnaires, forms or correspondence is true and complete.
- **Felony**: Claims for any period caused or contributed to by a Participant committing or attempting to commit an assault or felony, participating in an illegal occupation, actively participating in a violent disorder or not, or operating any vehicle while under the influence of any intoxicant. Actively participating does not include being at the scenes of a violent disorder or not while performing their official duties.
- **War**: Claims which arise out of, or are caused or contributed to by, war or an act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

How the Plan Works

High Deductible Plan (HDHP)

Your group healthcare plan is a High Deductible Health Plan (HDHP). This HDHP is a reimbursement plan. Covered healthcare expenses are reimbursed based on Total Allowable Charges after Deductible and Coinsurances are paid. Everything is subject to the Deductible, which means you must satisfy the individual or family Deductible amount before this Plan begins paying. This includes retail pharmacy services. The only exception is Preventive Services.

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. However, most doctor visits and Hospital Admissions do 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 for each service can be found in the *Summary of Benefits* of this document. The Coinsurance will be applied to the Total Allowable Charges or billed charges, whichever is less, for the particular procedure allowed by the Plan.

Provider Directory

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

If you need additional information about a Provider or would like to report an inaccuracy in the Provider Directory, you may call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5852** or **1-866-979-6778**. Hearing-impaired users may call **TTY 711**.

Additionally, you may submit a Provider Directory inaccuracy report online at **https://www2.phs.org/php_directory?insurance_plans=AHPH** and by navigating to the identified Provider's details page and choosing the *Report Inaccuracies* option.

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

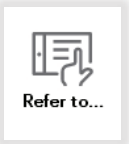
If our Provider Directory lists inaccurate information that you relied on in choosing a Provider, you will only be responsible for paying your In-network Cost-sharing amount for care received

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

Out-of-Network Providers

Out-of-network Providers do not have contractual agreements with Presbyterian Health Plan. Out-of-network services, as shown in the *Summary of Benefits*, apply when you obtain care from an Out-of-network Provider.

If you choose to receive routine care from Out-of-network Providers, payments by Presbyterian Health Plan for Covered Services will be **limited** to Reasonable and Customary Charges. For care other than Emergency or Urgent Care, you will be responsible for any balance due above the Reasonable and Customary Charges, in addition to any applicable Deductible or Coinsurance. Out-of-network Providers may require you to pay them directly at the time of service; you will then have to file your claim for reimbursement with Presbyterian Health Plan. Refer to the **Claims** Section of this document for more information on submitting such a claim.

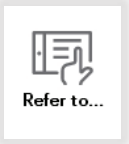


Some services are **Not Covered** when received from Out-of-network Providers. Please refer to your *Summary of Benefits* and throughout this document for a complete listing of Covered Services.

National PPO Providers

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

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



For additional information regarding National Network Providers or to see if you need a **Prior Authorization** for Out-of-network Services, please call our Presbyterian Customer Service Center prior to obtaining services Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5258** or **1-866-979-6778**. Hearing-impaired users may call **TTY 711**.

Cost-Sharing – Your Out-of-Pocket Costs

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.*

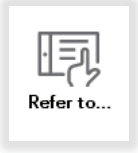
Annual Calendar Year Deductible

The amount of your Calendar Year Deductible can be found in the *Summary of Benefits.* 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.

For Single Coverage, the Member must meet the applicable individual Deductible as outlined in the *Summary of Benefits*. If Family Coverage is elected, the entire Family Deductible must be met before benefits will be paid. One Family Member may satisfy the entire amount for the whole family.

Coinsurance

For most services provided, 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 for Coinsurance amounts.



Annual Out-of-pocket Maximum

To protect you and your covered Dependents from the high cost of catastrophic illness, there is a maximum on the total Copayment or Coinsurance amount you must pay in a Calendar Year for Covered Services. This total amount is referred to as your Out-of-pocket Maximum. After your Out-of-pocket Maximum is reached, the Plan pays 100 percent up to Reasonable and Customary charges, for Covered Services for the remainder of that Calendar Year, up to the maximum benefit amounts. Please refer to your *Summary of Benefits* for your Plan's Individual and Family Out-of-pocket Maximum amounts.

The amounts are calculated as follows:

- **In-network:** Out-of-pocket Maximum (OOPM) includes Deductible and Coinsurance amounts only, including Prescription. Does not include charges for non-Covered Services, any penalties and any additional benefit charges.
- **Out-of-network**: OOPM includes only the Out-of-network Deductible and Coinsurance amounts for Covered Services, including Prescription. Does not include charges for Non-Covered Services, any penalties and any additional benefit charges such as expenses in excess of Reasonable and Customary amounts. Out-of-pocket expenses accrued under the In-network Option do not accrue toward the Out-of-network Out-of-pocket Maximum and vice versa.

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.* **Note:** If a Member's individual Out-of-pocket is met, no more charges incurred by that Member may be used to satisfy the family Out-of-pocket.

The Out-of-pocket Maximum is listed in the *Summary of Benefits* and includes only the Copayment and Coinsurance amounts listed in the *Summary of Benefits.* Penalty amounts, non-covered charges, any amounts over Reasonable and Customary Charges are **not** included in the Out-of-pocket Maximum.

Changes to Calendar Year/Family 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 had 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.

To inquire about the status of your specific Annual Out-of-pocket Maximum, you may call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5258** or **1-866-979-6778**. Hearing-impaired users may call **TTY 711**.

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 a Presbyterian Health Plan Member Services Representative.
- 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) 923-5258 or 1-866-979-6778.

Prior Authorization

This Section explains what Covered Healthcare Services require Prior Authorization before you receive these services and how to obtain Prior Authorization. This is not an exhaustive list. Further information can be obtained through your PCP or at our website at https://www.phs.org/tools-resources/member/prior-authorization.

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

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**.

Certain procedures or services, as identified in the next subsection of this document, do require **Prior Authorization**. The responsibility for obtaining this **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.
- When you seek specific Covered Services from an Out-of-network Provider (including National Network Providers), **you** are responsible for obtaining **Prior Authorization** from us before receiving the Out-of-network Services. **If Prior Authorization (Certification) is not obtained when required, then we may not Cover the services, and you may be responsible for the resulting charge**. You may have your Out-of-network or National Network Provider contact us on your behalf in order to provide necessary clinical information, but it is not the Out-of-network Provider's responsibility to obtain Prior Authorization.

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 Family Coverage, **Prior Authorization** requirements apply to your family Members who are also covered persons.

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

Prior Authorization is required as outlined in the following sections. In-network Providers request **Prior Authorization** when needed. If you obtain services from an Out-of-network Provider, it is your responsibility to obtain the needed **Prior Authorization.** Failure to do so (for Out-of-network Providers) will result in benefits being reduced or denied.

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 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 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

If PHP 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 provision. Other Covered Services are paid as explained in the *Summary of Benefits* and the **Benefits** Section. If the Admission is not for a covered service, no payment is made.

Note: All Admissions for Behavioral Health and Alcoholism and/or Substance Use Disorder services require **Prior Authorization** from PHP's Behavioral Health Department. Failure to obtain **Prior Authorization** may result in benefits being reduced or denied. For emergencies, PHP's Behavioral Health Department must be notified by the end of the next business day or as soon as reasonably possible, or benefits may be denied.

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.

Prior Authorization – Other Medical Services

Prior Authorization requirements are subject to change at the discretion of PHP with the approval of TriCore. Contact the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5258** (in Albuquerque), or toll-free within New Mexico at **1-866-979-6778**. TTY users may call **7**11.

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.

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, you will have to obtain **Prior Authorization**. Discuss the need for Prior Authorizations with your Provider before obtaining any of the following services:

- Acute Medical Detoxification (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the **Benefits** Section)
- All Hospital admissions, Inpatient non-emergent (listed under Hospital Services-Inpatient in the **Benefits** Section)
- Bariatric Surgery
- Blood glucose specialized monitors/meters, including those for the legally blind
- Bone growth stimulators
- Clinical Trials (Investigational/Experimental) (listed under Clinical Trials in the **Benefits** Section)
- Certified Hospice Care
- Computed Axial Tomography (CAT) scans in an outpatient setting (listed under Diagnostic and Imaging Services in the **Benefits** Section)
- Detoxification (acute requiring medical intervention)
- Durable Medical Equipment (listed under Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids in the **Benefits** Section)
- Electroconvulsive Therapy (ECT)
- Epidural Injections for Back Pain
- Foot Orthotics (listed under Orthotic Appliances in the **Benefits** Section)
- Genetic Testing
- Home Health Care Services/Home Health Intravenous Drugs (listed under Home Health Care Services/Home Intravenous Services and Supplies in the **Benefits** Section)
- Home uterine monitoring
- Hospital Admissions
- Hyperbaric Oxygen (listed under Hyperbaric Oxygen Therapy in the Benefits Section)
- Injectable Drugs, includes Specialty Medications and Medical Drugs (listed under Preventive Health Services for Women and also Practitioner/Provider Services in the **Benefits** Section)
- Insulin pumps
- Magnetic Resonance Imaging (MRI) in an outpatient setting (listed under Diagnostic and Imaging Services in the **Benefits** Section)
- Mental Health Services - Inpatient, Partial Hospitalization and select outpatient services (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the **Benefits** Section)
- Mobile Cardiac Outpatient Telemetry and Real-Time Continuous Attended Cardiac Monitoring Systems
- Non-emergency care when traveling outside the U.S.

- Nutritional Supplements (listed under Nutritional Support and Supplements in the **Benefits** Section)
- Observation Services greater than **24 hours**
- Organ transplants (listed under Transplants in the **Benefits** Section)
- Orthotics
- Podiatric and Orthopedic Appliances
- Positron Emission Tomography (PET) scans in an outpatient setting
- Prescription Drugs/Medications
- Prosthetic Devices (listed under Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids and also Women's Healthcare in the **Benefits** Section)
- Proton Beam Irradiation
- Reconstructive and potentially cosmetic procedures (listed under Reconstructive Surgery and also Women's Healthcare Services in the **Benefits** Section)
- Repair or replacement of non-rental Durable Medical Equipment
- Selected Surgical/Diagnostic procedures:
    - Ankle Subtalar Arthroereisis
    - Blepharoplasty/Brow Ptosis Surgery
    - Breast Reconstruction following Mastectomy
    - Breast reduction for gynecomastia
    - Endoscopy Nasal/Sinus balloon dilation
    - Hysterectomy
    - Lumbar/Cervical Spine Surgery
    - Meniscus Implant and Allograft/Meniscus Transplant
    - Panniculectomy
    - Rhinoplasty
    - Tonsillectomy
    - Total Ankle Replacement
    - Total Hip Replacement
    - Total Knee Replacement
    - Varicose Vein Procedures
- Skilled Nursing Facility care
- Special Inpatient services (including but not limited to private room and board and/or special duty nursing)
- Special Medical Foods (listed under Genetic Inborn Errors of Metabolism Disorders (IEM) and also Prescription Drugs/Medications)
- Substance Use Disorder Services, Inpatient (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the **Benefits** Section)
- Temporo/Craniomandibular Joint Disorders (TMJ/CMJ) (listed under Dental Services (Limited) in the **Benefits** Section)
- Transplant Services (listed under Transplants in the **Benefits** Section)
- Virtual Colonoscopy (listed under Clinical Preventive Health Services in the **Benefits** Section)

- Wireless Capsule Endoscopy

Prior Authorization Requirement

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

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

A complete and current list of the services subject to **Prior Authorization** can be found here: **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000030435**.

The prescription drugs that are subject to a **Prior Authorization** requirement can be found at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739**.

Prior Authorization Process

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

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

Prior Authorization Review Timelines

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

- **Urgent Care or Prescription Drugs**: If you require urgent medical care, behavioral healthcare or a Prescription Drug, we will resolve the request within **24 hours**.
- **Non-Urgent Medicine**: If you do not have an urgent need for a Prescription Drug, we will resolve the request within three business days if your Provider:
    - Uses the P**rior Authorization** request form approved by the New Mexico Office of Superintendent of Insurance;
    - Requests an exception from an established step therapy process; or
    - Requests to prescribe a drug that we do not usually cover.
- **Other Requests**: We will resolve all other requests within **seven business days**.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff can answer questions your Provider might have concerning required information or any aspect of the request submission process. If we require

additional information to evaluate a request, we will request it from your Provider. Your Provider will have at least **four hours** to provide requested information in connection with an urgent **Prior Authorization** request and at least **two calendar days** for any other type of request.

Why We Review

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

After Care Review

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

Behavioral Healthcare

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

Authorization Denial

We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process is included in this document. Please refer to the Table of Contents. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

Record of Prior Authorization

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

Prescription Drug Prior Authorization Protocols

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

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

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

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

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

Benefits

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

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

Medical Necessity

Medically Necessary - 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 (PHP'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 alternative services 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

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

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.

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

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

Care Coordination and Case Management

PHP'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.

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

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

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

Disease management health coaches work with you to help you better manage your chronic disease, such as Asthma, Coronary Artery Disease, Diabetes, or Hypertension. Care is focused on helping you identify self-management goals for improving management of your chronic disease.

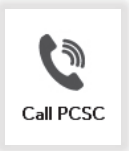
PresRN

PHP 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 PHP Members. Please call **(505) 923-5570** or **1-866-221-9679**.

Health Management Programs

Our clinically trained Healthcare Professionals work with your Practitioners/Providers to help enhance your quality of life in three areas: Staying healthy, living with illness, and Getting

Better. We help you reach optimum health through Clinical Preventive Health Services (such as Screening Mammography and childhood immunizations) as well as with disease management for conditions such as asthma, depression, diabetes, smoking cessation, and high-risk pregnancies.



If you would like more information about these services, please call our Presbyterian Customer Services at **(505) 923-5258** or **1-866-979-6778** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Also, visit our website at **https://www.phs.org/tools-resources/member**.

Covered Benefits

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

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

Urgent Care

Urgent Care is Medically Necessary medical or surgical procedures, treatments, or Healthcare Services you receive in an Urgent Care Center or in a Practitioner's/Provider's office for an unforeseen condition due to illness or injury. Urgent conditions are not life-threatening but require prompt medical attention to prevent a serious deterioration in your health.

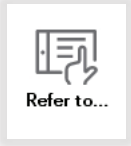
If you believe the condition to be treated is life-threatening, you should seek Emergency Healthcare Services as outlined below.

Emergency Healthcare Services

This *Summary Plan Description* covers acute Emergency Healthcare Services **24 hours** per day, **seven days** per week when those services are needed immediately to prevent jeopardy to your health. If Emergency Healthcare Services are administered by either an In-network or Out-of-network Provider, benefits for the initial treatment are paid at the In-network benefit level.

An Emergency includes but is not limited to severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the plan, per the plan Administrator's discretion, that an Emergency did exist. The plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

If you, as a result of Emergency Healthcare Services, are admitted to an Out-of-network Hospital, you may choose to be transferred to a Hospital that is in our Provider network (In-network). You must be medically stable and able to be safely transferred. Refer to **Ambulance Services** in the *Summary of Benefits and Coverage* for the required Cost Sharing for inter-facility transportation costs. If you choose to remain at an Out-of-network Hospital after you are medically stable and able to be safely transferred, Out-of-network benefits will apply.



Emergency shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in:

- Jeopardy to the person's health (or, with respect to a pregnant woman, the woman's unborn child)
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Disfigurement to the person

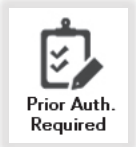
Prior Authorization is not required for Emergency Healthcare Services. If you are admitted as an Inpatient to the Hospital, you or your Practitioner needs to notify us within **48 hours** so we can review your Hospital stay.

For Emergency Healthcare Services outside of our Service Area, you may seek Emergency Healthcare Services from the nearest appropriate facility where Emergency Healthcare Services can be rendered. These services will be Covered as In-network services. Non-emergent follow-up care received from an Out-of-network Provider is Covered at the Out-of-network level of benefits.

Observation Services

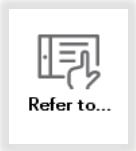
Observation services are defined as Outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff which are reasonable and necessary to:

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



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

for greater than 24 hours will require Authorization. It is the responsibility of the facility to notify us.



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

Ambulance Services

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

The following types of Ambulance Services are Covered:

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

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

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

Necessary services rendered unless otherwise limited or excluded under this Agreement.
    - Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

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

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

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

Coverage for High-Risk Ambulance Services is limited to:

- Air Ambulance Service when Medically Necessary. However, we will not pay more for air Ambulance Service than we would have paid for transportation over the same distance by ground Ambulance Services unless your condition renders the utilization of such ground Ambulance Services medically inappropriate.
- Maternity/Neonatal Ambulance Services, including ground or air Ambulance Service to the nearest Tertiary Care Facility, is limited to:
    - The medically high-risk pregnant woman with an impeding delivery of a potentially viable infant.
    - When necessary to protect the life of a newborn.
- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

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

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

Bariatric Surgery

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

- Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 40 kg/m^2 or greater who are at high risk for increased morbidity due to specific obesity-related co-morbid medical conditions provided by an In-Network Provider, and
- Is a Covered Benefit only if a Member meets these criteria and all other requirements of this Agreement

Member must have demonstrated adherence with all prescribed medications and treatment instructions. Appropriate documentation is required. Specific obesity-related co-morbidities include, but are not limited to:

- Cardiomyopathy
- Congestive heart failure with an ejection fraction of 50 percent or less than predicted
- Documentation of previous myocardial infarction requiring hospitalization
- Documented Type 2 diabetes mellitus
- Uncontrolled/massive leg lymphedema
- Obstructive sleep apnea with baseline AHI or RDI of 15 or greater, or currently under treatment with a positive pressure device (CPAP, BiPAP, C-Flex, etc.)
- Obesity-related osteoarthritis of the lower extremities for which joint replacement surgery of the knee or ankle has been recommended
- Pickwickian syndrome or cor pulmonale

Prior Authorization may be required.

Clinical Trials

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

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

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

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

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

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

Routine patient care costs do not include:

- The actual clinical trial or the investigational service itself
- Cost of data collection and record-keeping that would not be required but for the clinical trial; items and services provided by the clinical trial sponsor without charge
- Travel, lodging, and per diem expenses
- A service that is clearly inconsistent with widely accepted and established standards for a particular diagnosis
- 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.

Certified 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** from PHP. **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, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for a **Prior Authorization** with your Provider before obtaining services.

The Hospice benefit period is defined as follows:

- Beginning on the date your Provider certifies that you are terminally ill with a life expectancy of six months or less.
- Ending six months after it began unless you require an extension of the Hospice benefit period below or upon your death.
- If you require an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and your Provider must **re-authorize** your medical condition to us. We will not Authorize more than one additional Hospice benefit period.
- You must be a Covered Member throughout your Hospice benefit period.

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 the following:

- 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 **10 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 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

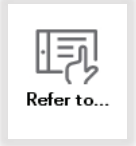
Chemotherapy/Dialysis/Radiation Therapy

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
- Treatment of disease by X-ray, radium, or radioactive isotopes

Clinical Preventive Health Services

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



We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing if you receive these services from our In-network Providers. If you receive these services from Out-of-network Providers, you are responsible for the Out-of-network level Cost Sharing amounts. Refer to your *Summary of Benefits and Coverage* for Out-of-network Cost-Sharing amounts.

We will provide Coverage for preventive benefits, as defined by the Affordable Care Act (ACA), if you receive these services from our In-network Providers, without cost-sharing regardless of sex assigned at birth, gender identity, or gender of the individual.

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

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

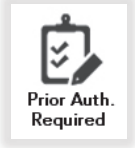
You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/patient/preventive-care-guidelines**.

Screening and Counseling Services

Screenings and counseling services will provide coverage for evidence-based services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force for individuals in certain age groups or based on risk factors. Key screenings include:

- Abdominal aortic aneurism screening for men ages **65 to 75 years** old who have ever smoked.
- Anxiety in Children and Adolescents: Screening ages **8 to 18 years** old.
- Prediabetes and Type 2 diabetes mellitus screening for adults ages **35 to 70 years** old who are overweight or obese.
- Screening for human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and domestic violence and abuse.
- Heart Artery Calcification scans are a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function. These scans are Covered for individuals between the ages of **45 to 65** years. Refer to the Heart Artery Calcification section for more details.
- Fall prevention screening for adults **age 65** or older.
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- Hepatitis B screenings for persons at high risk of infection.
- Hepatitis C screenings for adults ages **18 to 79 years** old.
- Latent tuberculosis screening for high-risk populations.
- Lung cancer screenings for ages **50 to 80 years** with a history of smoking.
- Preventive Physical Examinations.
  Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication adults aged **40 to 75 years** who have one or more cardiovascular risks.
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam.

- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level.
- Periodic stool examination for the presence of blood for all persons **45 to 75 years** of age or older.
- Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:



    - Fecal occult blood testing (FOBT)
    - Flexible sigmoidoscopy
    - Colonoscopy, and polyp removal when performed as a screening
        - Anesthesia services are also at no Cost-Share to Covered members when performed as part of Colonoscopy screening
    - Virtual colonoscopy – requires **Prior Authorization**
    - Double contrast barium enema
- After a colonoscopy, any pathology exam that's required for a biopsy, anesthesia, a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test.
- Smoking Cessation Program – refer to Smoking Cessation Counseling/Program in this Section.

- Screening to determine the need for vision and hearing correction in children.
- Periodic glaucoma eye test.
- Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions.
- Hypertension in Adults: Screening adults **18 years or older** without known hypertension.
- Syphilis infection screening in persons who are at an increased risk for infection and pregnant women.
- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV, STIs, and counseling, as well as counseling for drug and tobacco use, healthy eating and other common health concerns.
- Health education and consultation from In-network Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members **19 years** of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.
- Certain prescription drugs for preventive care, the treatment of illness, behavioral health, or substance use disorders will be Covered at no charge to you, when obtained from a participating pharmacy. See your Plan's Covered drug list for details.

Mammography 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 to 39**, one mammogram biennially to persons **age 40 to 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.

Routine Immunizations

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

- The Advisory Committee on Immunization Practices Centers for Disease Control and Prevention
- The U.S. Preventive Services Task Force (USPSTF)
    - HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP)

Childhood Preventive Health Services

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

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

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

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

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

Preventive Health Services for Women

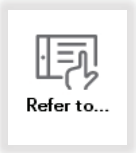
We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.

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

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

- Well-woman visits to include adult and female-specific screenings and preventive benefits.
- Breast cancer: medication use to reduce risk.

- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for **one year** after delivery.
- Cervical cancer screening every three years for women **21 to 65 years of age** who are at average risk.
- Chlamydia and gonorrhea screenings for sexually active women age **25 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.
    - Coverage of a six-month supply of contraceptives at one time, provided that the contraceptives are prescribed and self-administered.
- Counseling and screening for HIV, STIs and domestic violence and abuse.
- Counseling interventions for pregnant and postpartum persons who are at an increased risk of perinatal depression.
- Folic acid for the prevention of neural tube defects: preventive medication.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- HIV screening and counseling for sexually active and pregnant women. For pregnant women, the screening will be covered at any point of the pregnancy, even those who present in labor with an unknown status
- HPV DNA test: High-risk HPV DNA testing every **three years** for women with normal cytology results.
- HPV vaccine coverage for HPV as approved by the 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 screenings in pregnant women throughout pregnancy.
- Aspirin use to prevent preeclampsia and related morbidity and mortality: preventive medication for pregnant persons at high risk for preeclampsia.
- Screenings and counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling.
- Sterilization services for women only. Other services, performed during the procedure, are subject to deductible and coinsurance as outlined in your *Summary of Benefits and Coverage*.
- Urinary incontinence screening.



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

Complementary Therapies

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

Acupuncture

Acupuncture treatment is a benefit only if performed by a licensed Provider, 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,* in combination with chiropractic. In addition, for ancillary treatment modalities associated with Acupuncture services, other Plan limitations may apply.

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 PHP.

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

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.

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

Benefits for covered biofeedback services, including office calls, are limited to the conditions listed above.

COVID-19

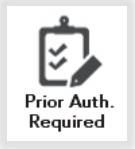
As a Presbyterian Health Plan Member, we provide coverage for COVID-19 testing, medical treatment, or vaccination, including boosters. Your coverage is subject to standard plan deductibles or coinsurance for services related to COVID-19, whether at a clinic, hospital, or using remote care.

Dental Services (Limited)

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

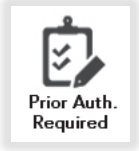
Dental benefits will be provided in connection with the following conditions when deemed Medically Necessary except in an emergency situation as described in the **Accidental Injury (trauma), Urgent Care, Emergency Healthcare Services and Observation Services Section**. Covered Services are as follows:

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



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

    - For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
    - For other procedures for which Hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involve the fascia or have spread beyond the dental space.
- Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- Temporo/Craniomandibular Joint Disorders (TMJ/CMJ).
    - The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) are subject to the same conditions, limitations and require **Prior Authorization** as they apply to treatment of any other joint in the body.



Diabetes Services

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

Diabetes Education (Limited)

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/Coinsurance 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.

- **Insulin pump training** - One initial session and one follow-up session.
- **Type 1 diabetes** - For Members 18 years of age and under, 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 six visits to normalize glucose within two months of diagnosis; then up to one visit per month for the first year following diagnosis; thereafter, up to four visits per year.
- **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 during pregnancy only (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.

- **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.

Diabetes Supplies and Services

When prescribed by the Member's Attending Provider, the following equipment, supplies, appliances and services are available from a Durable Medical Equipment supplier and are covered for Members with diabetes:

- Standard blood glucose monitors
- Visual reading urine and ketone strips
- Insulin
- Injection aids, including those adaptable to meet the needs of the legally blind
- Prescriptive oral agents for controlling blood sugar levels
- Medically Necessary podiatric appliances for prevention 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 for prevention and treatment when **Prior Authorization** is obtained from Presbyterian Health Plan
- Insulin pumps when Medically Necessary and prescribed by an In-network endocrinologist

For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), see your Prescription Benefits.

Your In-network Provider will request **Prior Authorizations** for you. If you access care from an Out-of-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.

Diabetes 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:

- 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 when Medically Necessary, prescribed by a participating endocrinologist
- 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

Prior Authorization is also required for items purchased from a vendor and costing $500 or more. Your In-network Provider will request **Prior Authorizations** for you. If you access care from an Out-of-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.

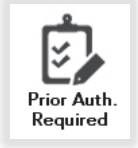
For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), see your Prescription Benefits.

Diagnostic and Imaging Services

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

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

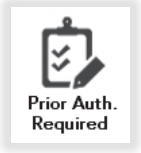
- Artery calcification testing (plan year 2022 and after)
- Computerized Axial Tomography (CAT) scans – requires **Prior Authorization**
- Magnetic Resonance Angiogram (MRA) tests, Magnetic Resonance Imaging (MRI) tests – require **Prior Authorization**
- Sleep disorder studies in-home or facility. (In facility sleep studies require **Prior Authorization**)
- Bone density studies
- Clinical laboratory tests
- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiology/X-ray services
- Diagnostic breast exams
- Supplemental breast exams
- Biomarker testing



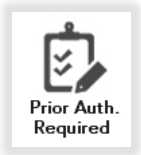
Durable Medical Equipment and Appliances, Hearing Aids, Medical Supplies, Orthotics, and Prosthetics

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

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



Custom Orthotic Appliances

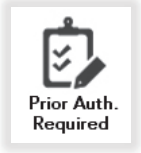


Custom Orthotic Appliances include braces and other external devices used to correct a body function, including clubfoot deformity. Custom Orthotic Appliances require **Prior Authorization**.

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

- Foot Orthotics or shoe appliances are not Covered, except for our Members with diabetic neuropathy or other significant neuropathy
- Prefabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for our Members in accordance with nationally recognized guidelines

Prosthetic Devices

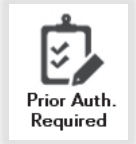


Prosthetic Devices are artificial devices, which replace or augment a missing or impaired part of the body. The purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are Covered when they replace a limb or other part of the body, after accidental or surgical removal and/or when the body's growth necessitates replacement. Prosthetic Devices require **Prior Authorization**.

Examples of Prosthetic Devices include, but are not limited to:

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

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



Repair and replacement of Durable Medical Equipment, Prosthetics and Custom Orthotic Devices requires **Prior Authorization**, except when provided for diabetes-related services. All diabetes-related services are provided in accordance with State law. Please refer to the Diabetes Services Section.

Repair and replacement are Covered when Medically Necessary due to change in your condition, wear or after the product's normal life expectancy has been reached.

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

Surgical Dressing

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

Gradient compression stockings are Covered for:

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

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

Eyeglasses and Contact Lenses (Limited)

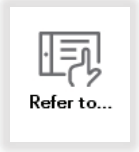
The following will only be Covered:

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

Hearing Aids

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

- Plan pays up to $2,200 every 36 months per hearing-impaired ear for school-aged children under 18 years old (or under 21 years of age if still attending high school). Refer to your *Summary of Benefits and Coverage* for your Cost Sharing (Deductible, Coinsurance and/or Copayment) amount.



- Shall include fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by a Provider licensed in New Mexico.

Family Planning and Related Services

Family planning services are covered for the following procedures:

- 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.)
- RU486 (Mifeprex) administered by a Provider

Infertility diagnosis and treatment, including drugs and injections administered in the Participating Provider's office and approved by Presbyterian Health Plan, Inc. in accordance with accepted medical practice for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery. Artificial insemination is Covered for up to three inseminations. Donor sperm is not Covered. In-vitro, GIFT and ZIFT fertilization are not Covered. Reversal of voluntary sterilization is not Covered. Infertility diagnosis and treatment, including drugs and injections, are not Covered if received from non-Participating Providers/Practitioners.

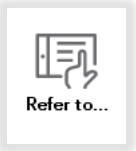
Genetic Inborn Errors of Metabolism Disorders (IEM)

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

Coverage is provided for diagnosing, monitoring, and controlling of disorders of IEM where there are standard methods of treatment, when Medically Necessary and subject to the **Limitations, Exclusions, and Prior Authorization** requirements listed in this Agreement. Medical services provided by licensed Healthcare Professionals, including Practitioners/Providers, dieticians and nutritionists with specific training in managing Members diagnosed with IEM, are Covered.

Covered Services include:

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

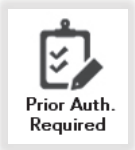


Refer to your *Summary of Benefits and Coverage* for applicable Cost Sharing amounts (office visit Copayments, Inpatient Hospital, outpatient facility, and other related Deductibles, Coinsurance and/or Copayments).

Genetic Testing

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

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



Habilitative Services

Autism Spectrum Disorder

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

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

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

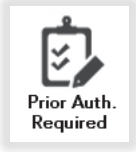
Limitation – Services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years of age who have Autism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

Home Health Care Services

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

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, 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 Provider 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

You may call our Presbyterian Customer Service Center for more information at **(505) 923-5258** or **1-866-979-6778** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Hospital Services – Inpatient

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

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.

If your In-network Provider recommends you be admitted, your In-network Provider will obtain **Prior Authorization**. If an Out-of-network Provider recommends you be admitted, you must obtain **Prior Authorization**. If **Prior Authorization** is not obtained, the Member will be responsible for a penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

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 PHP. If the Member requests a private room or the private room is not Medically Necessary, PHP 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

Benefits are available for blood transfusions, blood plasma, and 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 PHP 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.

Hospitalization for rehabilitation must begin while the Member is covered under this Plan. Inpatient rehabilitation treatment must be Medically Necessary and **not** for personal convenience.

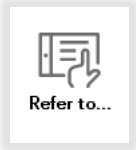
Benefits are **not** available for care that is not provided by a PHP-authorized facility. These Inpatient services are not eligible for any additional benefits on an Outpatient basis.

There are **no** benefits for Maintenance Therapy or care provided after the patient has reached 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.

Mental Health Services and Alcohol and Substance Use Disorder Services

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

To obtain benefits for Outpatient services related to Behavioral Health, it is **not** necessary to obtain **Prior Authorization**. However, all Inpatient Behavioral Health services and Alcoholism/Substance Use Disorder services require **Prior Authorization**. You can call the PHP's Behavioral Health Department directly at **(505) 923-5258 or 1-866-979-6778** for more information.



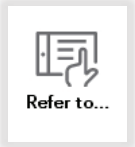
The following benefits and limitations are applicable for Behavioral Health and Alcoholism or Substance Use Disorder Services. In all cases, Behavioral Health treatment and Alcoholism and/or Substance Use Disorder treatment must be Medically Necessary in order to be covered. Day/visit limitations listed in the *Summary of Benefits* apply to the 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 & Drug Use Disorder Counselors (L.A.D.A.C.) with master's degree in counseling or social work

Mental Health Services

Some mental health services require Prior Authorization. The In-network Behavioral Health Providers will be responsible for obtaining Prior Authorization when required. For Out-of-network Services, Members need to contact our Behavioral Health Department to obtain Prior Authorization, when required except when requesting emergency services. Mental health services that require Prior Authorization are inpatient hospitalization, partial hospitalization, and residential treatment. Please refer to the **Prior Authorization Section** for services that require Prior Authorization. Contact our Presbyterian Customer Service Center at **(505) 923-5258** or **1-866-979-6778**.

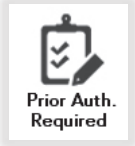


For assistance with accessing or for questions related to mental health services, you may do the following:

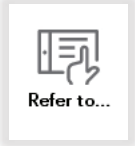
- Schedule an appointment with a behavioral health provider
- Call your primary care provider (PCP)
- Call our Presbyterian Customer Service Center at **(505) 923-5258** or **1-866-979-6778**

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

Alcohol and Substance Use Disorder Services



To obtain Alcoholism/Substance Use Disorder services, Members may contact our Presbyterian Customer Service Center at **(505) 923-5258** or **1-866-979-6778**. The Behavioral Health Provider will be responsible for any additional **Prior Authorizations**. Inpatient detoxification services require prior authorization except when requesting emergency services.



Acute Medical Detoxification Benefits are Covered under Inpatient and Outpatient Medical Services found in the Benefits Section of this Agreement. Some services require Prior Authorization except when requesting emergency services. For Out-of-network Services, Members need to contact our Behavioral

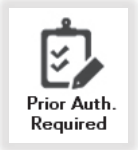
Health Department in order to obtain Prior Authorization, when required. Please refer to the **Prior Authorization Section**.

Provider Services

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

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

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



Some Provider services require **Prior Authorization**. Refer to the **Prior Authorization Section** for Prior Authorization requirements.

This Benefit includes, but not limited to, consultation and Healthcare Services and supplies provided by your Provider as shown below:

- Office visits provided by a qualified Practitioner/Provider.
- PHP Video Visits provided online between a designated Provider and patient about non-urgent healthcare matters.
    - PHP Video Visits utilize a nationwide network of providers and are $0 for all members that are not on a qualified high-deductible plan.
    - Telehealth appointments through video or telephone are with a network provider, including Presbyterian Medical Group providers. They require most members to pay a normal copay or cost share. Just like with an in-person visit.
    - Online Visits are an online Medical interview followed by a response from a Presbyterian Medical Group provider. They are $0 for all members not on a qualified high-deductible plan.
- Outpatient surgery and Inpatient surgery, including necessary anesthesia services. Hypnotherapy is Covered as part of anesthesia preparation.
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care.
- Allergy Services, including testing and serum.
- Sterilization procedures.

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

Prescription Drugs/Medications

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

Covered Prescription Drugs/Medication Benefit (Outpatient)

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

For a complete list of these drugs, please see the Presbyterian Health Insurance Exchange Metal Level *Formulary* list at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00199170**.

Affordable Care Act (ACA)

We will provide Coverage for preventive medications and products as defined by the Affordable Care Act (ACA) if you receive these services from our In-network Practitioners/Providers without cost sharing regardless of sex assigned at birth, gender identity, or gender of the individual.

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

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

Smoking Cessation Treatments

The following preventive medications and products for smoking cessation treatments are available with no cost sharing: Nicotine gum, Nicotine patches, Nicotine lozenges, Nicotine oral or nasal spray, Nicotine inhaler, bupropion, and Chantix (varenicline).

Visit the *Formulary* listing at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00199170**. Preventive medications will be listed as $0 Copay per PPACA. For preventive medications (including over-the-counter medications) or products to be Covered, you'll need to get a prescription from your Provider and a pharmacy claim will need to be submitted. Present your ID card to the dispensing pharmacy for processing and billing information.

For more information contact our Presbyterian Customer Service Center at **(505) 923-5258 or 1-866-979-6778**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Contraception Coverage

You are entitled to receive certain covered contraception services and supplies without Cost Sharing and without prior approval from us. This means that you do not have to make a Copayment, Coinsurance, satisfy a Deductible or pay out-of-pocket for any part of contraception benefits listed in this summary if you receive them from an In-network Provider.

You may be required to pay a copay, coinsurance, and/or a deductible if you receive a contraception service or supply from an out-of-network provider if the same service or supply is available In-network.

Methods of preferred generic oral contraceptives, injectable contraceptives, or contraceptive devices. The oral contraceptives covered by your plan are listed here: **https://client.formularynavigator.com/Search.aspx?siteCode=0045707827**.

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

Covered Contraceptive Methods

Your plan covers these contraceptive methods:

- Sterilization Surgery for Women
- Sterilization Surgery for Men
- IUD Copper
- IUD with Progestin
- Implantable Rod
- Shot/Injection
- Oral Contraceptives (The Pill) (Combined Pill)
- Oral Contraceptives (Extended/Continuous Use)
- Oral Contraceptives (Mini Pill – Progestin Only)
- Patch
- Vaginal Contraceptive Ring
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Male Condom
- Female Condom
- Spermicide

- Emergency Contraceptive

Long Acting Reversible Contraceptives

The Long Acting Reversible Contraceptives (LARCs), including Intrauterine Devices (IUDs) covered without cost-sharing by your plan are listed here: **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00199170.** Coverage with no Cost Sharing also applies to IUD insertion and removal, including surgical removal, and to any related medical examination when services are obtained from an In-network provider. Coverage of LARCs with no Cost Sharing also includes (pre-discharge) postpartum clinical services.

Six-Month Dispensing

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

Brand Name Contraceptives or Devices

Your plan may exclude or apply cost sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Refer to the list of contraceptive categories above. Ask your Provider about a possible equivalent.

If your Provider determines that a brand-name contraceptive is medically necessary, your Provider may ask us to cover that contraceptive without Cost Sharing. If we deny the request, you or your Provider can submit a grievance to contest that denial.

Vasectomies and Male Condoms

This plan covers vasectomies and male condoms. Your plan covers male condoms with no Cost Sharing, after the deductible is met, even when a Prescription is not required. Please see the section below on **Coverage for Contraception Where a Prescription Is Not Required** for instructions on reimbursement for condoms.

Sexually Transmitted Infections

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

Confidentiality

We require all In-network Practitioners/Providers and facilities to maintain confidential patient information in accordance with federal and state laws including, HIV/AIDS status, mental

health, sexually transmitted infections (STIs) or Alcohol/Substance Use Disorder. State and federal law prohibits further disclosure of HIV/AIDS, other STI, mental health and Alcohol Use Disorder and/or Substance Use Disorder information to any person or agency without obtaining specific valid written authorization for that purpose from the patient (or legal guardian/Personal Representative), or as otherwise permitted by state or federal law.

Coverage for Contraception Where a Prescription Is Not Required

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

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

Address: Presbyterian Health Plan
Pharmacy Department
P.O. Box 26267
Albuquerque, NM 87125-6267
Email: **askpharmacy@phs.org**
Fax: (505) 923-5540

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

Availability of Out-of-Network Coverage

Under your plan, use of an Out-of-network Provider to prescribe or dispense contraceptive coverage is a covered benefit. Please refer to **Out-of-network Care and Bills in the How the Plan Works Section** to learn more about your Out-of-network benefit.

What is a Formulary?

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

The primary purpose of the *Formulary* is to encourage the use of safe, effective and most affordable medications. Presbyterian Health Plan. administers a closed *Formulary*, which means

that Non-*formulary* drugs are not routinely reimbursed by the plan. Medical exception policies provide access to Non-*formulary* medication when Medical Necessity is established.

The medications listed on the *Formulary* are subject to change pursuant to the management activities of Presbyterian Health Plan. For the most up-to-date *Formulary* drug information, visit **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00199170.**

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

Can the Formulary change during the year?

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

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

If we remove drugs from our *Formulary*, add quantity limits, **Prior Authorization**, and/or step therapy restrictions on a drug, or move a drug to a higher Cost-Sharing tier, we must notify affected members of the change at least **60 days** before the change becomes effective.

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

- Reclassify a drug to a higher tier of the formulary
- Reclassify a drug from a preferred classification to a non-preferred classification, unless that Reclassification results in the drug moving to a lower tier of the formulary
- Increase the cost-sharing, copayment, deductible or coinsurance charges for a drug
- Remove a drug from the formulary
- Establish a prior authorization requirement
- Impose or modify a drug's quantity limit, or
- Impose a step therapy restriction

How is the Formulary Drug List Developed?

The medications and related products listed on a *Formulary* are determined by a Pharmacy and Therapeutics (P&T) Committee or an equivalent entity. The Presbyterian Health Plan., P&T

Committee is made up of primary care and specialty physicians, clinical pharmacists and other professionals in the healthcare field.

The P&T Committee meets quarterly to promote the appropriate use of drugs, to maintain the Presbyterian formularies, and to support our network of practitioners. Medications chosen for the *Formulary* are selected based on their safety, effectiveness and overall value. A medication may not be added to the *Formulary* if current drugs on the *Formulary* are equally safe and effective and are less costly. Utilization management strategies such as quality limits, step therapy and **Prior Authorization** criteria are reviewed and approved by the P&T Committee.

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

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

What is Prior Authorization?

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

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

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

Prescribed drugs will be considered for coverage under the pharmacy benefit when all of the following are met for any *formulary* or non-*formulary* request:

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

What is Step Therapy?

Step Therapy promotes the appropriate use of equally effective but lower-cost *Formulary* drugs first. With this program, prior use of one or more prerequisite drugs is required before a step therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step therapy drugs.

Presbyterian will not impose step therapy requirements before authorizing coverage for medication approved by the Federal Food and Drug Administration (FDA) that is prescribed for the treatment of a substance use disorder, pursuant to a medical necessity determination, except in cases in which a generic version is available.

What are Quantity Limits?

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

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

Biologic Medications

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

Daily Cost Sharing

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

Eye Drop Renewal

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

Insulin for Diabetes Cost Sharing Cap

The Copayment amount for a preferred *Formulary* prescription insulin drug or a Medically Necessary alternative will be Covered at an amount not to exceed a total of **$25.00** per **30-day** supply.

Medication Synchronization

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

Orally Administered Anti-Cancer Medications

This Plan provides coverage for orally administered anti-cancer medication used to slow or kill the growth of cancerous cells. Coverage of these medications are subject to the same Prior Authorization requirements as intravenously administered injected cancer medications Covered by the Plan.

Non-Extended Day Supply

Presbyterian has established protocols under the guidance of National Committee for Quality Assurance (NCQA) in an effort to ensure patients' safety for identified high-risk medications. Pursuant to this guidance, Presbyterian has limited the maximum allowed day supply down to **30 days** at a time for medications that fall into this high-risk category. These drugs are found in the Individual and Family Metal Plans/Employer Group Metal Plans *Formulary* as Non-Extended Day Supplies.

No Behavioral Health Cost Sharing

Formulary Prescription Drugs used for the treatment of mental illness, behavioral health, or Substance Use Disorders when obtained from a behavioral health specialist are covered at no Cost Share, after the deductible is met. Refer to the *Formulary* listing at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00199170** for additional coverage details. Coverage at no cost-share is subject to deductible first.

Drug Utilization Review and Drug use evaluation programs

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

Generic Drugs

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

Brand-Name Drugs When a Generic Equivalent is Available

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

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

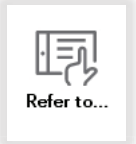
What if my Drug is not Covered?

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

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

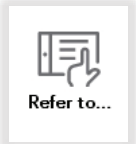
- You can ask us to cover your drug even if it is not on our *Formulary*.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more. Our review of a prior

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



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

For more information contact our Presbyterian Customer Service Center at **(505) 923-5258 or 1-866-979-6778,** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call our **TTY** line at **711**.



Additional information explaining the exception process can be found at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00199170.**

Benefit Limitations

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

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

Some medications may qualify for third-party copayment assistance programs which could lower your out-of-pocket costs for those products. For any such medication where third-party copayment assistance is used (Discount Cards or Prescription Drug Savings Cards), the Member will receive credit towards their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Self-Administered Specialty Pharmaceuticals

Self-Administered Specialty Pharmaceuticals are self-administered, meaning they are

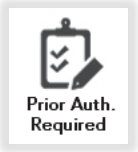
administered by the patient, a family member or caregiver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life- threatening conditions. Specialty Pharmaceuticals are often high cost, typically greater than $600 for up to a 30-day supply.

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

For a complete list of these drugs and formulary coverage, please see the Specialty Pharmaceutical listing at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00199170**.

For Specialty Pharmacy information please see the pharmacy services available at **https://www.phs.org/doctors-services/supporting-services/pharmacy-services.** You can call our Presbyterian Customer Service Center for additional information about the Presbyterian Specialty Pharmacy network, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5258 or 1-866-979-6778**. Hearing impaired users may call **TTY 711**.

Office Administered Specialty Pharmaceuticals (Medical Drug)



A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization,** and some must be obtained through the specialty network.

These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in the **Prescription Drug Coverage Section** in your *Summary of Benefits and Coverage*.

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

Mail Order Pharmacy

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

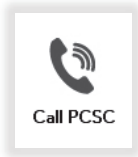
You may obtain more information on the Mail Service Pharmacy by calling our Presbyterian Customer Service Center at **(505) 923-5258 or 1-866-979-6778**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Member Reimbursement

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

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

- Patient's name
- Patient's date of birth
- Name of the drug
- Quantity dispensed
- NDC (National Drug Code)
- Fill date
- Name of prescriber
- Name and phone number of the dispensing pharmacy
- Reason for the purchase (nature of emergency)
- Proof of payment



Please see the Presbyterian Pharmacy website at **https://www.phs.org/doctors-services/supporting-services/pharmacy-services** to obtain a form or call our Presbyterian Customer Service Center at **(505) 923-5258 or 1-866-979-6778**, Monday through Friday from 7 a.m. to 6 p.m. **TTY** users may call **711**. Please follow the mailing instructions on the *Member Reimbursement* form.

A Pharmacy Services Call Center is available 24 hours a day to providers, pharmacies and members to address pharmacy benefit questions. Please contact Presbyterian Customer Service Center at **(505) 923-5258** or **1-866-979-6778** (follow the voice prompts and select Pharmacy).

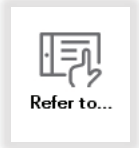
Rehabilitation and Therapy

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

Cardiac/Pulmonary Rehabilitation Services

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

Physical, Occupational and Speech Therapy



Benefits are limited as shown in the *Summary of Benefits* 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.

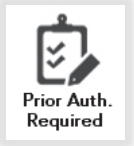
Benefits are **not** available for Maintenance Therapy or any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.

Skilled Nursing Facility Care

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

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, Custodial Care, or educational care.



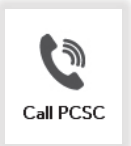
Note: **Prior Authorization** is required for Skilled Nursing Facility benefits. This benefit is limited, as shown in the *Summary of Benefits.* The Inpatient Copayment is waived if confinement in the Skilled Nursing Facility is within **15 days** after release from the Hospital and the stay is subject to continued stay review for Medical Necessity. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-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 Provider before obtaining services.

Smoking Cessation Counseling/Program

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

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

- Individual counseling at a Practitioner's/Provider's office is Covered under the medical benefit. The non-specialist Copayment applies. There is no limit to the number of visits that are Covered. Non-Participating Providers/Practitioners are not Covered.
- Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Practitioner/Provider. No Cost Sharing will apply, and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. You may want to utilize these services.
- Pharmacotherapy Benefits are limited to:
    - Two **90-day** courses of treatment per Calendar Year.
    - Refer to "Covered Medications" in your *Summary of Benefits* for Coinsurance amounts.



For more information, contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5258 or 1-866-979-6778**. Hearing-impaired users may call our **TTY** line at **711** or **1-877-298-7407**.

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

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

Also, most surgeries require a **Prior Authorization**. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-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 Provider.

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 as a consequence 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 lymphedema, 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.

The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plan and health insurance issuers that provide coverage for medical and surgical benefits with

respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).

Removal of breast Prosthesis is a covered benefit when deemed Medically Necessary. Replacement of the Prosthesis is **not** a covered benefit if the 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 PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See **Grievance** Section.

Transplants

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

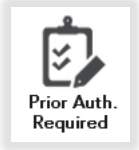
Transplant services include a surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

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

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; 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 retransplant. Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under "Surgery."

The treating Provider or Member must obtain **Prior Authorization** from PHP before benefits for any transplant procedure is provided. **Prior Authorization** must be obtained from PHP before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if **Prior Authorization** is not obtained from PHP. A PHP 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 Authorization 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 you have this **Prior Authorization**.

In addition, benefits are available **only** when the transplant is performed at a facility with a transplant program approved by PHP. Call the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5258** (in Albuquerque), or toll-free within New Mexico at **1-866-979-6778** for a current list of PHP approved programs. TTY users may call **711** or **1-877-298-7407**.

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 PHP case manager), Surgery, organ storage expenses and Inpatient follow-up care only. Donor organ procurement costs are subject to the maximum lifetime payment as shown in the *Summary of Benefits*.

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 Health Care maximums).

Reminder: Benefits are available only when the transplant is performed at a facility with a transplant program approved by PHP.

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 PHP-approved Organ Transplant facility. The term recipient is defined to include a Member receiving authorized transplant-related services during any of the following:

- Evaluation
- Candidacy
- Transplant event, or
- Post-transplant care

Travel expenses for the Member receiving the transplant will include charges for:

- 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
- 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 or for a transplant patient who is a minor, 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 maximum lifetime benefit shown in the *Summary of Benefits.*

Total benefits for transplant, services, and supplies provided after the transplant are limited to a lifetime maximum payment (excluding drugs for use while at home) per Member, as shown in the *Summary of Benefits*. Benefits applied toward this maximum include payments for Hospitalization and all allowable expenses for one or more transplants and for any subsequent Hospitalizations and medical services related to the transplant.

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, 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.

Women's Healthcare

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

Maternity and Newborn Care

Benefits include complete prenatal care, pregnancy-related diagnostic tests (including an alpha-fetoprotein IV screening test for women generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus), visits to an obstetrician, Certified Nurse-Midwife, or Licensed Midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse-Midwife or Provider. Lay midwife deliveries are **not** a covered benefit. 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 Family Coverage, a Dependent daughter is eligible for Maternity benefits. Coverage for the baby is available **only** if covered as an eligible Dependent.

Note: To add coverage for your newborn child, you must submit an Application for your child as a Dependent before or within **60 days** of birth. The baby is then covered from the moment of birth. If you have Employee coverage, you must change to Two-Party Coverage; if you have Two-Party Coverage, you must change to Family Coverage; if you already have Family Coverage, you must submit an Application to add your newborn as a Dependent.

However, if you do not apply for your newborn child within **60 days** of birth, you must wait until the next special enrollment period authorized by TriCore to enroll the child.

Once the baby is enrolled, newborn visits in the Hospital by the baby's Provider, circumcision, incubator, and routine Hospital nursery charges are covered. If your baby needs special care, including diagnostic tests and Surgery, the Plan pays benefits for that care too.

A separate Inpatient Copayment for your newborn applies only when the infant's Inpatient stay exceeds the mother's date of discharge. Additional services beyond routine newborn care are not subject to an additional Copayment if the infant is discharged on the same day or before the mother is discharged from the Hospital.

If your newborn stays in the Hospital longer than you, the mother, you must notify PHP Health Services by calling **(505) 923-5757** or toll-free **1-888-923-5757** before the mother is discharged from the Hospital to coordinate the baby's care, or benefits may be reduced or denied.

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 authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

General Limitations

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

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

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

Benefit Limitations

The benefits below have limits applied.

Acupuncture treatment benefits for covered expenses, in combination with services provided for chiropractic, are limited to a Calendar Year Maximum as outlined in the respective *Summary of Benefits.*

Behavioral Health Services (Inpatient) 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, 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, or a professional Psychologist.

Chiropractic (manipulations) services for covered expenses, in combination with services provided for Acupuncture, are limited to a Calendar Year Maximum as outlined in the respective *Summary of Benefits.*

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

Consumable medical supplies are covered during Hospitalization. They are also covered during an office visit or authorized home health visit. PHP **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
- Primarily used for a medical purpose
- Generally are useful only to a person who is ill or injured
- Ordered or prescribed by a licensed Provider

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 prostheses, craniomandibular joint (CMJ) and temporomandibular joint (TMJ) disorders, pediatric anesthesia and oral Surgery benefits are Covered when Medically Necessary. Also, 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:

- Some services when **Prior Authorization** is not obtained from PHP (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 exostosis; 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 appliances
- Orthopedic appliances

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.

Durable Medical Equipment, Orthotic and Prosthetic Devices and external prostheses require **Prior Authorization** when costs exceed $500. In addition, rentals, repairs or replacements require **Prior Authorization**.

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.

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

Home Health Care services require **Prior Authorization**, or no benefits are payable through the Plan.

Hospice care benefits are limited to patients who are terminally ill, as described in the **Benefits** Section. **Prior Authorization** from the Plan is required.

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.

Preventive services are limited as listed on the *Summary of Benefits* and suggested frequency schedules in the **Benefits** Section.

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

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 will be limited to two respite stays of up to **10 continuous days** per benefit period.

Routine eye screenings are limited to Dependents through age 17.

Routine hearing screenings are limited to Dependents through age 17, except as outlined under the **Benefits** Section.

Transplants and related services and supplies provided after the transplant are limited to a **lifetime maximum benefit payment of $500,000 per Member**. Benefits for travel, lodging, and meals are limited to an adult transplant recipient and one other person. For minor children, benefits are payable for two adults. Lodging and meals are limited to $125 per day per person, including the transplant patient (to a maximum lifetime benefit payment of $10,000) to include transportation. Donor organ procurement costs for the surgical removal, storage, and transportation of the donated organ are covered for Reasonable and Customary Charges. All payable benefits for transplants accumulate towards the $500,000 lifetime maximum amount payable.

Exclusions

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

Any service, supply, item or treatment not listed as a covered service in the **Benefits** 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.

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

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
- Residential Treatment Centers used for the treatment of any condition
- 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 Reasonable and Customary 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 **Benefits** 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, infertility treatment, or gender changes 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 or 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.

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

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

Custom-Fabricated ankle-foot orthoses and/or knee-ankle-foot orthoses (AFO and/or KAFO) except for Members up to eight years old when **Prior Authorization** is obtained from PHP.

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 the service is provided by a licensed or registered Provider.

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 consist chiefly of room and board, even if therapy is included.

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

Duplicate coverage including, but not limited to:

- Services already covered by other valid coverage;
- Services already paid under Medicare or that would have been paid if the 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 services as described in the **Benefits** 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/treatments 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 **Benefits** Section.

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

Functional foot orthotics, including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by PHP), are **not covered**, except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from PHP.

Gender-affirming and reversals of such procedures are **not covered** benefits.

Hair loss, including wigs, artificial hairpieces, hair transplants, or implants, even if there is a medical reason for hair loss.

Hearing exams: 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 17 as part of a routine physical exam, or
- Covered as outlined under “Hearing Aids” above

Home births are not a covered benefit.

Home Health Care benefits 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

In addition, 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 Gonadotropin (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."

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 the Plan.

Infertility testing and treatment is not a covered benefit under this Plan. 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 PHP 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.

Legal payment obligations: Services for which the Member has no legal obligation to pay or that are free, charges made only because benefits are available under this Plan, services for which the Member has received a professional or courtesy discount, services provided by the Member upon oneself or a covered family Member, or by one ordinarily residing in the Member's household, or by a family member, or Provider charges exceeding the amount specified by the Health Care Authority when benefits are payable under Medicare.

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

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

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.

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

Medically unnecessary services: This Plan does not cover services that are not Medically Necessary as defined in the **Benefits** Section unless such services are specifically listed as covered.

Membership fees are not a covered benefit under this Plan.

Meniscal Transplants are not a covered benefit under this Plan.

Non-covered Providers: 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.

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 except as listed in the **Benefits** Section.

Orthodontic appliances and treatment, crowns, bridges, or dentures for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders unless the disorder is trauma related. Also, nonstandard diagnostic, therapeutic and surgical treatments of TMJ are not 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 PHP.

Orthoptics are not a covered benefit under this Plan.

Orthotripsy is 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.

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: Except as otherwise required by applicable law, 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.

Private room expenses are **not a covered** benefit under this Plan unless there is documented medical necessity.

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.

Rolfing is **not covered** under this Plan.

Self-help programs and therapies not specifically covered in this booklet, such as behavior modification, music, art, dance, recreation and Z therapy.

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.

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

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

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.

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

Weight loss program, obesity treatment, and nutritional counseling expect as outlined in the **Benefits** Section.

Termination

How Coverage Stops

Coverage under this Plan terminates on the last day of the earliest of the following:

- The period in which premiums are paid
- On the date when eligibility ceases, or
- When the Plan ends

If a Dependent becomes ineligible due to age, coverage ceases at the end of the month following their birthday.

If a Dependent loses eligibility due to marriage or divorce, coverage ends the end of month the change has been received by the TriCore Employee Benefits Department.

Coverage under this SPD does not end for any Member who is a Hospital Inpatient at the time of the membership termination until benefits applicable to the Admission are exhausted or until the Member is discharged from the Hospital, whichever occurs first.

How to Disenroll Dependents

When you lose a Dependent through marriage, death, divorce, annulment, or legal separation, or a Dependent is ineligible due to age, please submit an Application and any supporting documentation (marriage certificate, final divorce paperwork, proof of other coverage, etc.) to disenroll the Dependent from your coverage. Contact your agency group representative for the necessary forms.

Certificate of Coverage

If your coverage is terminated, the Claim Administrator provides evidence of your prior health coverage by supplying you with a Certificate of Coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for a pre-existing condition or if you want to buy, for you or your family, an individual insurance policy.

Continuation of Coverage Under the Family and Medical Leave Act (FMLA)

If you take a leave of absence that qualifies as a Family and Medical Leave under the Family and Medical Leave Act of 1993 (an FMLA leave), medical coverage for you and your family Members continues as long as you continue paying your portion of the cost of coverage during the FMLA leave. Your agency group representative will advise you of the methods available to continue paying for your coverage. If you elect to discontinue medical coverage during an FMLA leave and subsequently return to work, your coverage will be reinstated with no waiting

period or pre-existing condition limitation. For additional information on FMLA leave and the effect on your benefits, please contact your agency group representative.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

TriCore supports voluntary military service with the United States armed forces and complies with all laws that protect your rights to benefits during or following a period of military service. If you leave TriCore employment to serve in a branch of the United States armed forces, you may be eligible to apply for reemployment in conformance with the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments thereto. Contact the TriCore Employee Benefits Department to discuss your rights under this law.

Continuation of Coverage Under Consolidated Omnibus Budget Reconciliation Act (COBRA)

This Plan is subject to the provisions for continuation of plan coverage under Federal law Consolidated Omnibus Budget Reconciliation Act (COBRA). The employee and their covered Dependents who lose eligibility under this Plan may continue as Group Members for a limited period of time.

On April 7, 1986, a new Federal law was enacted (Public Law 99-272, Title X "COBRA") requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of healthcare coverage (called COBRA continuation of coverage) at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation of coverage provisions of this law. Both you and your spouse should take the time to read this section carefully.

If you are an employee of TriCore covered by this healthcare plan, you have the right to choose this continuation coverage if you lose your group health coverage due to a reduction in your hours of employment below **30 hours** per week; or change in employment category to Temporary, Occasional/Seasonal or On-call; or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Group healthcare plan, you have the right to choose continuation of coverage for yourself if you lose group health coverage under the Group's plan for any of the following reasons:

- The death of your spouse
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment as outlined above
- A Divorce from your spouse, or
- Your spouse becomes entitled to Medicare benefits

A Dependent child of an employee covered by the Group's healthcare plan has the right to continuation of coverage if group healthcare coverage under the Group's plan is lost for any of the following reasons:

- The death of the parent employee
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer
- Parent's divorce
- The Dependent ceases to be a Dependent child under the plan, or
- The parent employee becomes entitled to Medicare

Under this law, the employee or a family Member has the responsibility to inform the Plan Administrator (your agency group representative) of a divorce, legal separation, or a child losing Dependent status under the Group plan.

A COBRA qualifying event also occurs upon an employee's death, termination of employment, any reduction in hours that disqualifies the person for group coverage, or Medicare entitlement (in the case of terminating employees only).

Should one of the above events have occurred, the Plan Administrator will in turn notify you (within **14 days** of receipt of notification) that you have the right to choose continuation of coverage. Under this law, you have at least **60 days** from the date you would lose coverage due to one of these events or the date you receive the notice of your rights to choose continued coverage.

If you do not choose continuation of coverage, your group health coverage will end.

If you choose continuation of coverage, your employer is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family Members. This law requires that you be given the opportunity to maintain continuation of coverage for up to 36 months unless you lost group healthcare coverage due to a termination of employment or reduction in hours, in which case the required continuation coverage period is 18 months unless you have been determined to be disabled under the Social Security Act, in which case the required continuation coverage period is 29 months. However, this law also provides that your continuation coverage may be cut short for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees
- The premium for your continuation coverage is not paid on time
- You become covered under another group health plan as a result of employment or re-employment (whether or not you are an employee of that employer) unless the new plan contains an exclusion or limitation relating to any pre-existing condition you may have
- You are a widow or were divorced from a covered employee and subsequently remarry and are covered under your new spouse's health plan unless the new plan contains an exclusion or limitation relating to any pre-existing condition you may have

- You become entitled to Medicare benefits (coverage may continue for your spouse), or
- You are determined to no longer be disabled (shortens the extended period)

You do not have to show that you are insurable to choose continuation coverage. However, under this law, you will pay 102% (150% in the case of the 19th through 29th month for a disabled person) of the full premium for your continuation coverage.

For more information regarding COBRA, contact your agency group representative.

COBRA and the Family and Medical Leave Act (FMLA)

A leave that qualifies as a Family and Medical Leave under the FMLA does not make you eligible for COBRA coverage. However, whether or not you lose coverage because of nonpayment of premiums during a Family and Medical Leave, you may be eligible for COBRA on the last day of the leave, which is the earliest of the following:

- The date you unequivocally inform the TriCore Employee Benefits Department that you are not returning at the end of the leave
- The date your leave ends, assuming you do not return, or
- The date the FMLA entitlement ends

For purposes of a Family and Medical Leave, you will be eligible for COBRA only if:

- You or your Dependent is covered by the plan on the day before the date the leave begins (or becomes covered during the leave)
- You do not return to employment at the end of the leave; and You or your Dependent loses coverage under the plan before the end of what would be the maximum COBRA continuation period

Claims

As a Member of this Plan, for payment to be made, you will generally not have claims to file or papers to fill out for medical services obtained from In-network Providers. In-network Providers will bill PHP directly. On occasion, you may access care from a non-contracted 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

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 a Presbyterian Customer Service Center representative.

The Member Claim Forms are available from your agency group representative or a Presbyterian Customer Service representative. They can also be printed out from our website at **www.phs.org**. Please mail the claim forms and itemized bills to:

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

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 Out-of-network, the Provider, the Hospital, or you should file the claims with PHP. If the Provider or Hospital does not file the claims, ask for an itemized statement and complete it the same way that you would for services received from an Out-of-network Provider. Payments for these services may be required to be made by you.

Claims Outside the United States

Even overseas, this Plan's coverage travels with you. If you need Hospital or Provider care, claims should be handled the same way as described in "Out-of-network Claims" above. 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.

Itemized Bills

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

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

The only acceptable bills are those from healthcare 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) includes services previously filed, clearly identify the new charges that you are submitting.

How Payments are Made

Payments to Out-of-network Providers are sent to the Out-of-network Provider when possible. However, PHP 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.

Provider payments are based upon In-network Provider agreements and the Negotiated Fee for Service as determined by PHP. 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. This may not apply to Emergency Medical Services or Urgent Care Services. See **Benefits** Section for more information. You are also responsible for paying all Copayments, Deductibles, 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 PHP.

You may be requested to have another Provider 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 PHP 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 PHP.

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 PHP 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 PHP.

Effects of Other Coverage

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

Coordination of Benefits

This Plan contains a coordination of benefits (COB) provision that prevents duplication of payments. Under this provision, if 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. 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 a Presbyterian Customer Service Center representative 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 unless a pre-existing condition limitation applies 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.
- Employee/Dependent. If the Member who received care is covered as the employee under one 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 employee, 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 employee;
    - If the Member has other valid coverage, please contact the other carrier's customer service center 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 Employee. If the Member who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active employee under one coverage and as the Dependent of the same but inactive employee 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.

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, PHP limits its secondary benefit payment to the difference between the PHP 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. If you do not meet these obligations and your primary benefits are reduced as a result, PHP limits its secondary benefit payment to the difference between the PHP 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. If you do not meet these obligations and your primary benefits are reduced as a result, PHP limits its secondary benefit payment to the difference between the PHP Negotiated Fee-for-Service for the service received and the amount that would have been paid if you had met the obligations.

Medicare

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 you are a working employee age 65 or over and your spouse is age 65 or over, you are eligible to continue coverage on the same basis as Members under age 65.

When a retiree becomes eligible for Medicare, Medicare is primary, and benefits are paid according to the Coordination of Benefits provisions of this Plan.

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 an employee 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 PHP 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.

Medicaid

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.

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, PHP 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 PHP's subrogation right. You must notify PHP if you file a claim, consult an attorney, or bring action against a third party. If contacted by PHP, you must provide all requested information. Settlement of a controversy without prior notice to PHP is a breach of this agreement. In the event that you fail to cooperate with PHP or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of PHP, PHP 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.

Summary of Health Insurance Grievance Procedures

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

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

What types of decisions can be reviewed?

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

Adverse determination: You may request a review if your insurer has denied preauthorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (The insurer must notify you before terminating or reducing coverage for an ongoing course of treatment and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by the insurer of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called adverse determinations.

Administrative decision: You may also request a review if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of healthcare services; claims payment, handling or reimbursement for healthcare services; or if your coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a healthcare service work?

When your insurer receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

- **Coverage**: First, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then your insurer will not agree to pay for you to have them even if you have a clear need for them.

- **Medical necessity**: Next, if the insurer finds that the requested service is covered by the policy, the insurer determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that your insurer pay for cosmetic plastic surgery to give you a more attractive nose, the insurer might certify the first request to repair your hand and deny the second, because it is not medically necessary.

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

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

How long does initial certification take?

Standard decision: The insurer must make an initial decision within 5 working days. However, the insurer may extend the review period for a maximum of 10 calendar days if it: **(1)** can demonstrate reasonable cause beyond its control for the delay; **(2)** can demonstrate that the delay will not result in increased medical risk to you; and **(3)** provides a written progress report and explanation for the delay to you and your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent care situation: An urgent care situation is a situation in which a decision from the insurer is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum function; **(3)** the physician with knowledge of your medical condition **reasonably** requests an expedited decision; **(4)** the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or **(5)** the medical demands of your case require an expedited decision.

If you are facing an urgent care situation or your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer must either certify or deny the

initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

If you are dissatisfied with the insurer's initial expedited decision in an urgent care situation, you may then request an **expedited review** of the insurer's decision by both the insurer and an external reviewer called an Independent Review Organization (IRO). When an expedited review is requested, the insurer must review its prior decision and respond to your request within 72 hours. If you request that an IRO perform an **expedited review** simultaneously with the insurer's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours after receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

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

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

If the initial request is approved, the insurer must notify you and your provider within one (1) working day after the decision, unless an urgent matter requires a quicker notice. If the insurer denies certification, the insurer must notify you and the provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your policy. The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows:

Phone: (505) 923-5258 or at 1-866-979-6778
Address: Presbyterian Health Plan
Attn: Appeals and Grievance Department
PO Box 26267

Albuquerque, NM 87125-6267
Fax: (505) 923-5124
Email: **info@phs.org**

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review

If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify the insurer that you wish to request an internal review within 180 days after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that the insurer review its decision, the insurer will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review: If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review: Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your pre-service request for review or within 60 days if you have already received the service. The medical director's review generally takes only a few days.

The medical director denied my request - now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer, or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent. If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider and ask questions of the panel members. Your health provider may also address the panel or send a written statement.

If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may **NOT** request an IRO review if you skip the panel review.

How long do I have to make my decision?

If you wish to have your request reviewed by the insurer's panel, you must inform the insurer within **5 days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?

If you request that the insurer provide a panel to review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone or arrange to have someone attend with you or on your behalf. You may review all of the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement.

The insurer's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you have already received the services. You will be notified within one (1) day after the panel decision. If you fail to provide records or other information that the insurer needs

to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

Hint: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 days.

If I choose to have my request reviewed by the insurer's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **4 months** to request a review by an IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with the insurer or with you. The reviewer will consider all of the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the insurer must provide them.

The IRO's fees are billed directly to the insurer – there is no charge to you for this service.

How long does an IRO review take?

The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within 30 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within 180 days after the date you are notified of the decision. The insurer will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

The insurer will mail a decision to you within 30 days after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have 20 days to request that the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after the insurer receives

your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 days.

The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within 20 days after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at **www.osi.state.nm.us**. You may also call OSI to request the forms at **(505) 827-4601** or toll free at **1-855-427-5674**.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has 5 days to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and the insurer and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with your personal healthcare records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

The preceding summary has been provided by the Office of the Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

Records

Your medical records are important documents needed in order to administer your Health Benefits Plan. This Section explains how we ensure the confidentiality of these records and how these records are used to administer your plan.

Creation of Non-Medical Records

We shall keep your records related to personal identification information, which does not specifically relate to your medical diagnosis or treatment. The individual member and/or Group shall forward information periodically as may be required by PHP in connection with the administration of this Agreement.

Accuracy of Information

PHP shall not be liable to fulfill any obligation which is dependent upon information submitted by the group or by you prior to its receipt in a satisfactory manner. We are entitled to rely on such information as submitted. We, at our sole discretion, may make any necessary corrections due to recognizable clerical error. We will date and initial the correction of the error.

Consent for Use and Disclosure of Medical Records

We are entitled to receive from any Practitioner/Provider of services Protected Health Information (PHI) about you to the extent permitted by applicable law, for any permitted purpose, including but not limited to, quality assurance, Utilization Review, processing of claims, financial audits or other purposes related to payment and certain of our healthcare operation activities. A determination of benefit Coverage may be suspended pending receipt of this information. **By acceptance of Coverage under this Agreement, you give consent to each Practitioner/Provider rendering services hereunder to disclose all information to us (to the extent permitted by applicable law) pertaining to you for any permitted purpose specified in the law**. This consent shall not permit a use or disclosure of PHI when an authorization is required by law or when another condition must be met for such use or disclosure to be permitted under applicable law. We will comply with the Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.

Professional Review

We are permitted by law to use your records to conduct professional/regulatory review programs for Healthcare Services without your consent/authorization. Such review programs include but are not limited to, the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and the Department of Insurance (DOI).

Confidentiality of Protected Health Information/Medical Records

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

What is PHI?

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

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

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

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

Access to PHI

All confidential documents are kept in a physically secure location with access limited to authorized Plan personnel only. You (or your legal guardian/Personal Representative) have the right, with certain exceptions, to request access to inspect and obtain a copy of your PHI. We may charge a reasonable fee for providing a copy, summary or explanation of the information you request. If there is a fee, we will tell you how much it will cost before we provide the requested information. You may change your request to avoid or reduce the fee.

You do not have the right to inspect or obtain a copy of PHI that consists of:

- Psychotherapy notes
- Information gathered in reasonable expectation of, or for use in, a civil, criminal, or Administrative action or proceeding
- PHI maintained by us that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 U.S.C. 263a, to the extent the provision of access to you

would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988 (CLIA), pursuant to 42 CFR 493.3(a)(2)

To request access to inspect or obtain a copy of your PHI, you must submit your request in writing to:

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

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

Routine Uses and Disclosures of PHI

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

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

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

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

Consents/Authorizations

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

In the event that the Practitioner/Provider fails to obtain such consent for disclosure to us, or you refuse to sign such consent for disclosure to us, we shall use our best efforts to obtain such written consent from you (or your legal guardian/Personal Representative) prior to the Practitioner's/Provider's release of PHI (i.e., health records) to us for purposes permitted by law. When you sign your enrollment form (Application), you are giving consent (to the extent permitted by applicable law) to the use or the release of your PHI by any person or entity, including without limitation, Practitioners/Providers and insurance companies, to us or our designees (including its authorized agents, regulatory agencies and affiliates) for any permitted purpose, including but not limited to, quality assurance, Utilization Review, processing of claims, financial audits or other purposes related to the payment, or certain healthcare operations activities of our Plan. This consent does not permit a use or disclosure of PHI when an authorization is required by law.

We will not further release PHI about you without your permission/authorization unless permitted or required by law.

We require all In-network Practitioners/Providers and facilities to maintain confidential patient information in accordance with federal and state laws including HIV/AIDS status, mental health, sexually transmitted diseases or alcohol/drug use. State and federal law prohibits further disclosure of HIV/AIDS, other sexually transmitted infection, mental health and alcohol use and drug use information to any person or agency without obtaining specific valid written authorization for that purpose from the patient (or legal guardian/Personal Representative), or as otherwise permitted by state or federal law.

To request an Authorization Form, please contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5258 or 1-866-979-6778**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407 or** visit our website at **www.phs.org**. Authorization Forms will be kept in your medical record or enrollment file.

Members Who Are Unable to Give Consent/Authorization

Sometimes courts or doctors decide that certain people are unable to understand enough to make decisions for themselves. Usually, a person with legal authority to make healthcare decisions for a child or other person (for example, a parent or legal guardian) can exercise the health information rights described herein for the child or other person, but not always. Unless otherwise required or permitted by law, when we need an Authorization Form signed for a

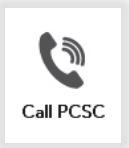
person who can't make healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

Right to Request Amendments (Changes) to PHI

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

Process for Members to Request an Accounting of Disclosures of PHI

You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5258 or 1-866-979-6778**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407** or visit our website at **www.phs.org**. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you to others without authorization from you.



Restriction of PHI Use or Disclosures

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

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

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

Use of Measurement Data

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

Internal Protection of Oral, Written and Electronic PHI Across PIC

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

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

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

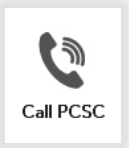
Website Internet Information

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

- Website traffic statistics, including:
    - Where visitor traffic comes from
    - How traffic flows within the website
    - Browser type
    - We monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful
- Personal information that you provide to us (such as your name, address, billing information, Health Benefit Plan enrollment status, etc.) if you fill out a form on our website
    - We use your personal information to reply to your concerns. We save this information as needed to keep responsible records and handle inquiries
    - We do not sell, trade, or rent personal information provided by visitors to our website to other persons, companies or partners

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

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



If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5258 or 1-866-979-6778**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407 or** visit our website at **www.phs.org**.

Eligibility, Enrollment, Effective Dates

This Section explains eligibility requirements for Subscribers and/or their Dependents, important effective dates, conditions for Termination of Coverage and continuing Coverage for Members who become ineligible for this plan.

Who is Eligible

To be eligible for Covered Benefits in accordance with the terms of this Agreement, you must be enrolled as a Member. To be eligible to enroll as a Member, you must be a Subscriber or a Dependent of the Subscriber and meet the criteria listed below.

Eligible Subscribers

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

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

Eligible Dependents

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

- Be your legally married spouse, as defined by state law and physically live in PHP's Service Area as defined by PHP; or
- Be your Domestic Partner who is not employed by TriCore; Domestic Partners are defined as couples who are in an exclusive and committed relationship for mutual benefit, similar to that of marriage. Domestic Partners must share a common, primary residence for 12 or more consecutive months and must be jointly responsible for each other's common welfare, as well as shared financial obligations. Domestic Partners must be at least 18 years of age and may not be married; nor can they be a member of another domestic partnership. Domestic partners are also forbidden from being blood relations to a degree of closeness that would prevent them from being married in their state of residence. A signed Affidavit of Domestic Partnership must be provided to TriCore Human Resources in order for a partner to be added as a Dependent;

- Be your Dependent child who is:
    - Under 26 years of age;
    - Your own or legally adopted child or a child for whom you are legal guardian or have legal custody as defined by state law;
    - In your Custodial Care as appointed by court order;
    - **Note**: Only the eligible court-ordered Dependent will be allowed to enroll. The eligible Dependent will become effective on the date in accordance with the court order. If the court order does not stipulate an effective date, the Dependent will become effective the first of the month following the date the court order was filed with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent will be the first of the month following receipt of the request by the employer. The employee of the Dependent must meet any applicable waiting periods imposed by the Group and only the eligible, court-ordered Dependent will be allowed to enroll. The waiting period requirement for all employees is the first of the month following **30 days** of employment.
    - Children of Domestic Partners. Benefits are also available to domestic partner's children provided that the child is primarily dependent upon the employee or domestic partner for support and one or both of the domestic partners is the biological child of the parent, adoptive parents of the child, or the child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or court order; with the exclusion of foster children.
    - Your stepchild (foster children are not eligible);
    - A child for which a court or qualified administrative order is imposed or a child of non-custodial parent(s).
    - Who depends on you for support. Dependent children who are eligible to be enrolled under this item 2. Subsection b. are not required to live in the Service Area. TriCore may require proof of eligibility. Enrollment of a Dependent child under this Contract shall terminate upon attainment of the child's 26th birthday, except as provided in item 2. Subsection d. below or earlier marriage; or
    - Be your or your spouse's Dependent child, under 26 years of age, for whom you are required by court order to provide healthcare Coverage. Dependent children who are eligible to be enrolled under this item 2. Subsection c. are not required to live in the Service Area, and Coverage is provided as described in Court-Ordered Coverage for Dependent Children. Enrollment of a Dependent child under this Contract shall terminate at the end of the month upon attainment of the child's 26th birthday.
    - The attainment of the limiting age referenced in item 2. Subsections b. and c., above, shall not terminate the Coverage under this Agreement of a Dependent unmarried child who is totally and permanently disabled. The Dependent must be incapable of self-sustaining employment by reason of mental disability or physical handicap and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish proof of such disability, incapacity and dependence to TriCore within **30**

days of the Dependent child's attainment of age 26, and each birthday thereafter if requested by TriCore.

Enrollment and Effective Dates

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

- Subscribers, together with eligible Dependents, may enroll by submitting completed application forms to TriCore. The signed and completed application form must be received by TriCore within **30 days** of the effective date.
- Subscribers and eligible Dependents may begin receiving services for Covered Benefits at 12:01 a.m. on the first day of the month following the date of hire if the names of the Subscribers and eligible Dependents have been received in writing by TriCore. (If the date of hire is on the first day of the month, then coverage begins at 12:01 a.m. on that day.) Please contact TriCore Human Resources for details.
- Newly hired employees of TriCore must enroll within **30 days** after becoming eligible. The effective time and date of Coverage will be 12:01 a.m. on the first of the month following completion of TriCore eligibility requirements. If enrollment is not accomplished within the **30-day** period, the next earliest time the eligible Subscriber and eligible Dependents may enroll is the next occurring Annual Enrollment Period except as specifically described below:
    - A child for whom a Subscriber becomes a legal guardian pursuant to court order is eligible to be enrolled as a Dependent for the duration of the guardianship unless otherwise ineligible for Coverage. Such child must be enrolled within **30 days** of the date of the court order granting guardianship. The Dependent will become a Member on the first day of the month following the date the order is filed with the clerk of the court.
    - A child for whom a Subscriber has been ordered by a court of law/qualified administrative order to provide healthcare Coverage is eligible to be enrolled as a Dependent provided that the Subscriber has met TriCore's waiting period requirements and the request for enrollment is made within **30 days** from the date on which TriCore receives the court/qualified administrative order. The TriCore's waiting period requirement for all employees is the first of the month following **30 days** of employment. The Dependent will become a Member on the day stipulated by the court order.
- An eligible person may enroll as a Subscriber or Dependent after the initial eligibility period if the person loses Coverage under all of the following circumstances:
    - The person was Covered under a Group health plan or had individual health insurance Coverage at the time the person was initially eligible to enroll; and
    - The employee stated in writing if requested by TriCore at the time the employee was initially eligible to enroll, that he and/or his Dependents were not enrolling because of such other Coverage; and
    - The person's Coverage under the other plan or insurance:

- Was under a COBRA continuation provision, and the Coverage under that provision was exhausted (and not voluntarily terminated);
- Was not under a COBRA continuation period, and either the Coverage was terminated as a result of loss of eligibility or employer contributions toward the Coverage were terminated; and
- Application was made within **30 days** of the date Coverage under COBRA was exhausted, or the date the Coverage (or the employer's contribution toward Coverage) was terminated

- Upon expiration of any applicable **30-day** period for eligibility, enrollment in this Plan can occur only during a subsequent Annual Enrollment Period.

Special Enrollment for Active Employees and Their Dependents

An employee who failed to enroll in this Plan during a previous enrollment period but who would otherwise be eligible for Coverage may enroll in this Plan due to a Special Enrollment event. Application must be made within **30 days** of acquiring a new Dependent through marriage, birth, adoption or placement for adoption or as specified by TriCore. Special Enrollment applies to the Subscriber, spouse and Eligible Dependents, which include the new Dependents acquired because of the marriage or newborn/adopted children who triggered the event, but not other siblings.

- Effective date of enrollment:
  - In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan, provided it is received within **30 days** of the date of marriage.
  - In the case of a Dependent's birth, the date of such birth and;
  - In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.
- CHIPRA (in accordance with provisions as currently may be defined under Federal law).
  - An employee, who chose not to enroll in this Plan for self and/or Dependent(s) during a previous enrollment period because they were Covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, may request coverage for self and/or any affected eligible Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of the date Medicaid or CHIP coverage terminated.
  - An employee, who chose not to enroll in this Plan for self and/or Dependent(s) during a previous enrollment period and has become eligible for group health premium assistance under State Medicaid or State CHIP, may request coverage for self and/or eligible Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of becoming eligible.
  - If you apply within **60 days** of the date Medicaid or CHIP coverage is terminated, or within **60 days** of the date the employee is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later than the first day of the month following receipt of your enrollment request.

Special Enrollment - Change in Family Status

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

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

- Court order/qualified administrative order to provide health insurance for an eligible Dependent.

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

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

Rescission

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

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

Glossary of Terms

This Section defines some of the important terms used in this Summary. Terms defined in this Section will be capitalized throughout the Summary.

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

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

Acute Medical Detoxification is a form of drug and alcohol use treatment in which a patient is weaned off their alcohol or drug addiction immediately with the help of medical supervision. It is a serious medical process that usually takes **three to five days**, depending on the substance.

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

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

Administrative Services Agreement (ASA) means the administrative agreement between us and the Group.

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.

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any

Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

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

Agreement means this Summary Plan Description, including supplements, Endorsements or riders, if any.

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

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

Ambulatory Surgical Facility means an appropriately licensed Provider, with an organized staff of Providers that meets all of the following criteria:

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

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

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

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

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

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.

Authorized means **Prior Authorization** was obtained (when required) prior to obtaining Healthcare Services both In-network and Out-of-network.

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

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

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions and thereby alleviate an abnormal bodily condition.

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.

Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection or treatment of cancer that is being provided in New Mexico.

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

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

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

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

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

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent Person (DSM-5-5- The Diagnostic & Statistical Manual of Mental Disorders Fourth Edition Copyright 1994).

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.

Complaint means the first time we are made aware of an issue of dissatisfaction that is not complex in nature. For more complex issues of dissatisfaction see definition for **Grievance**.

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

Continuous Quality Improvement means an ongoing and systematic effort to measure, evaluate and improve our processes in order to continually improve the quality of Healthcare Services provided to our Members.

Contract means the Application submitted as the basis for issuance of this Summary Plan Description (Summary). This Summary including the *Summary of Benefits and Coverage*, any supplements, Endorsements or riders, the Application, medical questionnaire (if applicable), the issued Identification Card, and the applicable Group Letter of Agreement or non-Group Membership Letter of Agreement constitute the entire Contract.

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

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 primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Cost Sharing means any contribution Members make towards the cost of their Covered Healthcare Services as defined in their health insurance Agreement. This includes Deductibles, Coinsurance and Copayments.

Coverage/Covered means benefits extended under this Agreement, subject to the terms, conditions, limitations, and exclusions of this Agreement.

Covered Benefits means benefits payable extended under this Agreement for Covered Health Services provided by Healthcare Professionals subject to the terms, conditions, **limitations and exclusions** of this Contract.

Covered Person means a policy holder, Subscriber, Enrollee, Member or other individual entitled to receive Healthcare Benefits provided by a Health Benefits Plan and includes Medicaid recipients enrolled in a Healthcare Insurer’s Medicaid plan and individuals whose health insurance Coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Health Care Purchasing Act.

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

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

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

Cytologic Screening (PAP Smear) means a Papanicolaou test or liquid based cervical cytopathology, a Human Papillomavirus Screening test and a pelvic exam for symptomatic as well as asymptomatic female patients.

Deductible is part of the contribution that Members make toward the cost of their healthcare, also known as Cost Sharing. It means the amount the Member is required to pay each Contract Year, directly to the Practitioner/Provider in connection with Covered Healthcare Services before Presbyterian Health Plan begins to pay Covered Benefits. The Deductible may not apply to all Healthcare Services.

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 Subscriber's family who meets the requirements of the Eligibility, Enrollment and Effective Dates Section of this Agreement, who is enrolled as our Member, and for whom we have actually received an Application and the payment.

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

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

Domestic Partner means two unmarried individuals who live together in a long-term relationship of indefinite duration. There must be an exclusive, mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other’s welfare and share financial obligations.

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

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

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

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

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

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

Refer to **Reasonable/Prudent Layperson** definition in this Glossary.

Endorsement means a provision added to the Summary Plan Description (SPD) that changes its original intent.

Enrollee means anyone who is entitled to receive Healthcare Benefits that we provide. Refer to **Member** in this Glossary.

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

Excluded Services means Healthcare Services that are not Covered Services and that we will not pay for.

Experimental or Investigational 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

Eye Refraction means the measurement of the degree of refractive error of the eye by an eye care specialist for the determination of a prescription for eyeglasses or contact lenses.

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

FDA means the United States Food and Drug Administration.

Formulary means a list of drugs approved for Coverage and the tier level at which each is Covered under this Agreement. Our Pharmacy and Therapeutics Committee continually updates this listing. A copy of this listing is available on our website at **www.phs.org** or by calling our Presbyterian's Customer Service Center Monday through Friday 7 a.m. to 6 p.m. at **(505) 923-5258 or 1-866-979-6778**. Hearing-impaired users may call **TTY** Line at **711** or **1-877-298-7407**.

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

Genetic Testing is a type of medical test that identifies changes in chromosomes, genes, or proteins. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder if that person has a known family history or classic symptoms of a disorder.

Genetic Inborn Errors of Metabolism (IEM) means a rare, inherited disorder that is present at birth and results in death or mental disability if untreated and requires consumption of Special Medical Foods. Categories of IEMs are as follows:

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

Good Cause means nonpayment of premium, fraud or a cause for cancellation or a failure to renew which the Superintendent of Insurance of the state of New Mexico has not found to be objectionable by regulation.

Grievance means any expression of dissatisfaction from any Member, the Member's Representative, or a Practitioner/Provider representing a Member.

Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or Practitioner/Provider acting on behalf of that person with that person's consent, entitled to receive healthcare benefits provided by the healthcare plan
- An individual, or that person's authorized representative, who may be entitled to receive healthcare benefits provided by the healthcare plan
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Health Care Purchasing Act

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

Habilitative Services means Services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally.

Health Benefits Plan means a health plan, or a policy, Contract, certificate or Agreement offered or issued by a Healthcare Insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Healthcare Services. This includes a traditional fee-for-service Health Benefits Plan.

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

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

Healthcare Professional means a 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 mental health Services, including community-based mental health Services, and Services for developmental disability or developmental delay.

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

Hearing Officer, Independent Co-Hearing Officer or ICO means a healthcare or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and Coverage issues that arise in external review hearings.

High Deductible Health Plan means the Plan option providing reimbursement for Total Allowable Charges only, subject to the Deductible, Out-of-pocket Maximum and Coinsurances.

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

Home Health Care Services means Healthcare Services provided to a Member confined to the home due to physical illness. Home Health Care Services and home intravenous Services and supplies will be provided by a Home Health Agency at a Member's home when prescribed by the Member's Practitioner/Provider, and we approve a **Prior Authorization** request for such Services.

Hospice means a duly licensed facility or program, which has entered into an agreement with us to provide Healthcare Services to Members who are diagnosed as terminally ill.

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

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

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

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

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

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

Independent 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.

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

In-network Provider means Providers, Hospitals, and other Healthcare Professionals, facilities, and suppliers that have a contract with Presbyterian Health Plan as In-network Providers.

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

Licensed Acupuncturist means an Acupuncture practitioner who is licensed by the appropriate state authority. 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.

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

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

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

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

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of Services or site of Services
- Contracts with selected healthcare Practitioner/Providers
- Financial incentives or disincentives for Covered Persons to use specific Practitioners/Providers, Services, prescription drugs, or service sites
- Controlled access to and coordination of Services by a case manager
- Insurer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care

Managed Health Care Plan (MHCP or Plan) means a Health Benefit Plan that we offer as a Healthcare Insurer that provides for the delivery of Comprehensive Basic Healthcare Services and Medically Necessary Services to individuals enrolled in the plan (known as Members) through our own contracted healthcare Practitioners/Providers. This Plan either requires a Member to use or creates incentives, including financial incentives, for a Member to use healthcare Practitioners/Providers that we have under contract. This Plan (Agreement) is considered to be a Managed Healthcare Plan.

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

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

Medicare Allowable means the maximum dollar amount that an insurer will consider reimbursing for a covered Service or procedure. This dollar amount may not be the amount ultimately paid to the provider as it may be reduced by any coinsurance, deductible or amount beyond the annual maximum.

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

Medical Drugs (Medications obtained through the medical benefit). A Medical Drug is any drug administered by a Healthcare Professional and is typically given in the member's home, Provider's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization,** and some must be obtained through the specialty network.

Medical Director means a licensed Provider in New Mexico, who oversees our Utilization Management Program and Quality Improvement Program, that monitors access to and appropriate utilization of Healthcare Services and that is responsible for the Covered medical Services we provide to you as required by New Mexico law.

Medical Necessity or Medically Necessary means 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 alternative 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 Title XVIII of the Social Security Act and all amendments thereto.

Member means the Subscriber or Dependent eligible to receive Covered Benefits for Healthcare Services under this Agreement. Also known as an Enrollee.

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

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

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

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

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

Occupational Therapist means a person registered to practice occupational therapy. An Occupational Therapist treats neuromuscular and psychological dysfunction caused by disease, trauma, Congenital Anomaly, or prior therapeutic process, through the use of specific tasks or goal-directed activities designed to improve functional performance of the patient.

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

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

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

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

- An institution or entity only listed as:
    - Ambulance Provider
    - Ambulatory Surgical Facility
    - Birthing Center
    - Durable Medical Equipment Supplier
    - Freestanding Dialysis Facility
    - Home Health Agency

    - Hospice Agency
    - Independent Clinical Laboratory
    - Pharmacy
    - Rehabilitation Hospital
    - Urgent Care Facility
- A person or practitioner only listed as:
    - Certified Nurse Midwife
    - Certified Registered Nurse Anesthetist
    - Chiropractor
    - Dentist
    - Licensed Acupuncturist
    - Licensed Practical Nurse
    - Occupational Therapist
    - Physical Therapist
    - Podiatrist
    - Licensed Lay Midwife
    - Registered Nurse
    - Respiratory Therapist
    - Speech Therapist

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

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

Out-of-pocket Maximum means 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, Reasonable and Customary Charges, non-covered expenses, and specifically excluded expenses and Services.

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.

Over-the-Counter (OTC) means a drug for which a prescription is not normally needed.

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Healthcare and Education Reconciliation Act of 2010 (Public Law 111-152).

Patient Protection and Affordable Care Act

In the event of a conflict between the provisions of your health plan and the provisions of the Act, the provisions that provide the better benefit shall apply.

"Essential Health benefits" means, to the extent covered under the Plan, expenses incurred with respect to covered Services, in at least the following categories: ambulatory patient Services, emergency Services, hospitalization, maternity and newborn care, mental health and substance use disorder Services and devices, laboratory Services, preventive and wellness Services, chronic disease management, and pediatric Services including oral and vision care. **The prohibition of annual dollar limits under the Affordable Care Act applies only to Essential Health Benefits.**

"Patient Protection and Affordable Care Act of 2010" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Healthcare and Education Reconciliation Act of 2010 (Public Law 111-152).

A Member's health coverage may not be rescinded (retroactively terminated) unless:

- The Employer or a Member (or a person seeking coverage on behalf of the Member) performs an act, practice or omission that constitutes fraud, or
- The Employer or Member (or a person seeking coverage on behalf of the Member) makes an intentional misrepresentation of material fact

Personal Representative means a parent, guardian, or other person with legal authority to act on behalf of an individual in making decisions related to healthcare.

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

PHP Video Visit means a virtual visit with a contracted provider. These visits are scheduled through the myPRES Portal.

PPACA means Patient Protection and Affordable Care Act.

PPO means Preferred Provider Organization.

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

Provider means any licensed Practitioner of the healing arts acting within the scope of their license.

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

Practitioner/Provider means any licensed Practitioner of the healing arts acting within the scope of their license.

Practitioner/Provider Assistant means a skilled person who is a graduate of a Practitioner/Provider Assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Practitioner/Provider Assistants, and who is licensed in the state of New Mexico to practice medicine under the supervision of a licensed Practitioner/Provider.

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

Preferred (as it refers to medication and diabetic supplies) means medication that is selected for inclusion on Preferred tiers of the Formulary based on clinical efficacy, safety, and financial value.

Premium means the amount paid for a Contract of health insurance.

Prepayment means the monthly amount of money we charge payable in advance for Covered Benefits provided under this Agreement in accordance with the applicable Administrative Services Agreement (ASA) or non-Group Membership Letter of Agreement.

Prescription Drugs/Medications means those drugs that, by Federal law, require a Provider's prescription for purchase. Prescription Drugs obtained on an Outpatient basis are not Covered under the medical portion of this Plan.

Primary Care Provider or Practitioner (PCP) means a Healthcare Professional who, within the scope of their license, supervises, coordinates, and provides initial and basic care to Members, who may initiate their referral for specialist care, and who maintains continuity of patient care. Primary Care Practitioners shall include but not be limited to general Practitioners, family practice Practitioner/Providers, internists, pediatricians, and Obstetricians-Gynecologists, Practitioner/Provider Assistants and Nurse Practitioners. Other Healthcare Professionals may also provide primary care as necessitated by a Member's healthcare needs. Members enrolled in the PPO plan have the choice of an In-network or Out-of-network Practitioner/Provider based on availability, without a referral.

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.

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

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

Provider Non-Discrimination means PHS Act Section 2706(a)(3), as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable state law "PHS" Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures. "Similar language is included in section 1852(b)(2) of the Social Security(4) Act and implementing HHS regulations(5)."

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

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 a particular case because of unusual circumstances

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 that are usual and customary, or which could not be considered excessive in a particular case because of unusual circumstances

Reconstructive Surgery means the following:

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

Registered 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.

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

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

Rescission of Coverage means a cancellation or discontinuance of Coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of Coverage has only a prospective effect, or
- The cancellation or discontinuance of Coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums, Prepayments or contributions towards the cost of Coverage

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program and has staff available **twenty-four hours** a day.

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

Service Area means the entire state of New Mexico.

Screening Mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic Members and includes the X-ray examination of the breast using equipment that is specifically for mammography, including the X-ray tube, filter, compression device, screens, film, and cassettes, and that has a radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast. Screening Mammography includes the professional interpretation of the film but does not include diagnostic mammography.

Service Area means the geographic area in which we are authorized to provide Services as a Health Maintenance Organization and includes the entire state of New Mexico.

Short-term Rehabilitation means Rehabilitation Services and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected. See *Summary of Benefits and Coverage* for the number of visits.

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 care 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.

Spouse - Legally married husband or wife.

Statutory Minimum HDHP Deductible means the minimum Deductible that a health plan must have to be a TriCore 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.

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

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

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

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

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

Superintendent means The Superintendent of Insurance.

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
- 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.

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

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

Termination of Coverage means the cancellation or non-renewal of Coverage provided by a Healthcare Insurer to a Covered Person/Grievant but does not include a voluntary termination by a Covered Person/Grievant or termination of the Health Benefits Plan that does not contain a renewal provision.

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

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

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

Traditional Fee-for-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Covered Persons/Grievants to utilize preferred (In-network) Practitioners/Providers, to follow pre-authorization (**Prior Authorization)** rules, to utilize Prescription Drug Formularies or other cost-saving procedures to obtain Prescription Drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for Services.

Two-Party Coverage means coverage for the employee and their spouse or coverage for the employee and one Dependent child.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by a Healthcare Insurer consistent with the federal, national, and professional practice guidelines that are used by a Healthcare Insurer in determining whether to certify/authorize or deny a requested Healthcare Service.

Urgent Care Center means a facility operated to provide Healthcare Services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

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

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

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

Vocational Rehabilitation means Services that are required in order for the individual to prepare for, enter, engage in, retain or regain employment.

Well-child Care means routine pediatric care and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

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

Acceptance Page

TriCore agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the TriCore Medical Plans: HDHP.

Signed By:_____ Date:_____

TriCore Manager

Exhibit A – Statement of ERISA Rights

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

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

Article I. Receive Information about your Plan and Plan Benefits

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

Section 1.01 Continue Group Health Plan Coverage

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

Article II. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your

plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining healthcare benefits or exercising your rights under ERISA.

Section 2.01 Enforce Your Rights

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

Section 2.02 Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210 or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272.**

Notice of 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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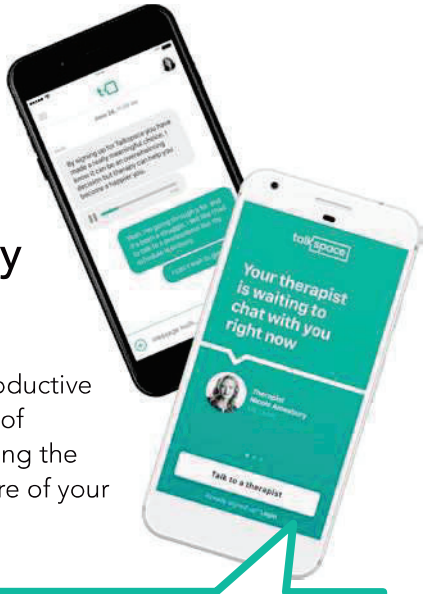
French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 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.

Talkspace for Behavioral Health

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



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

What is messaging therapy?

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

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

How it works

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

What's in it for you?

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

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

With Talkspace you can:

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

Getting started

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

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

talkspace

PRESBYTERIAN

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

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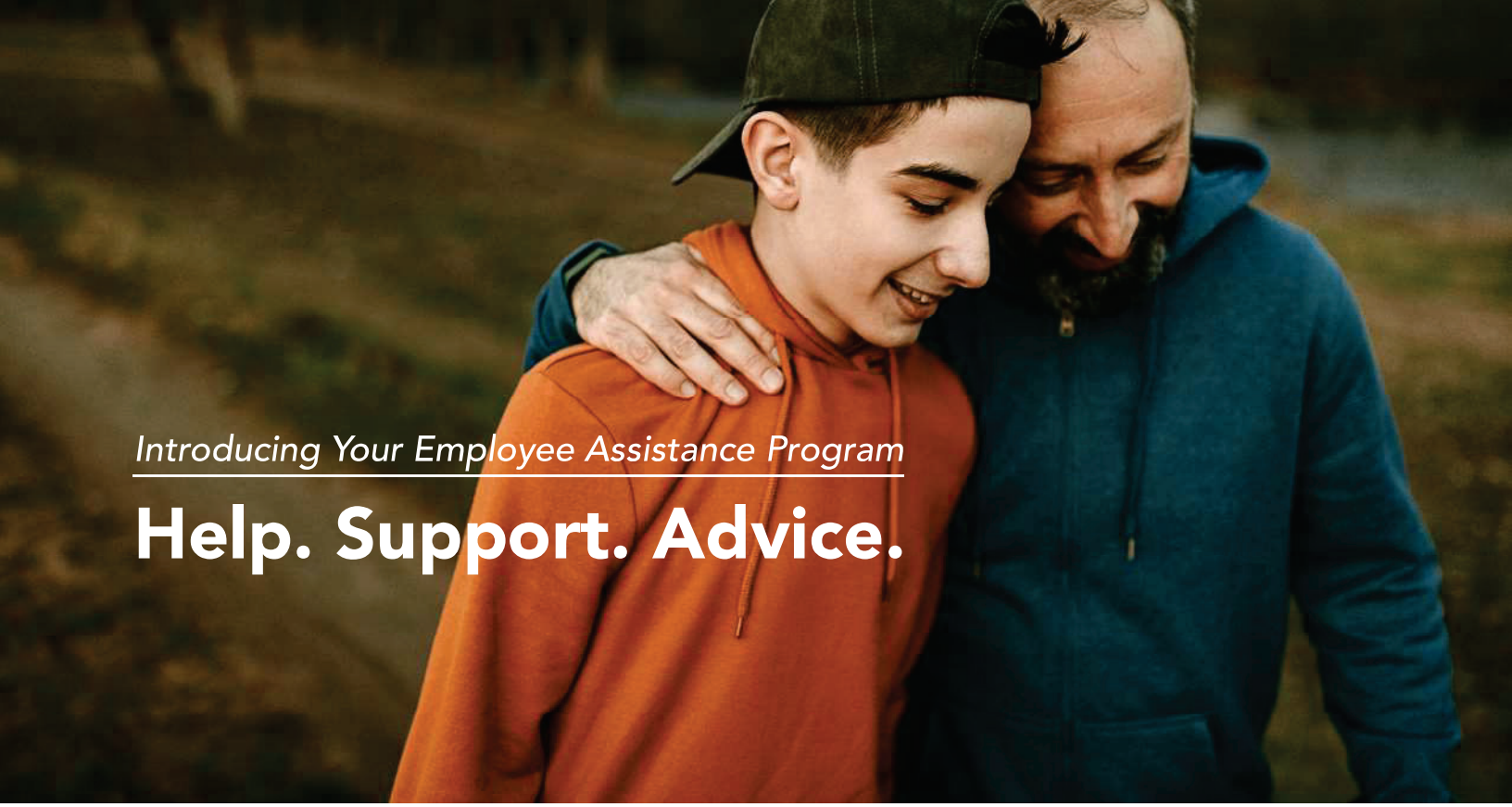

Introducing Your Employee Assistance Program

Help. Support. Advice.

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

You and your household members can get up to six employee assistance visits per issue through The Solutions Group, a division of Presbyterian Healthcare Services.

Employee Assistance Program (EAP) services are short-term, confidential counseling sessions conducted by local licensed providers and can include:

- mediation services
- substance use assessments and referrals
- 24-hour emergency services
- support for supervisors and managers
- referrals for additional support

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

Services provided by:

The Solutions Group

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TruHearing®

1-833-731-4168 | TTY: 711

Larry is wearing TruHearing Advanced hearing aids.

Hearing aid savings made simple.

Thanks to Presbyterian Health Plan, you have access to special savings on high-quality prescription hearing aids through TruHearing®. Don't miss another moment. It's easy to get started.

Your 2026 hearing benefit covers up to two TruHearing Premium or Advanced hearing aids per year with low copayments.

	Hearing aid	Avg retail price per aid	Savings per aid	**Your cost per aid**
Presbyterian Health Plan **Exam: $45 copay**	TruHearing Premium	$3,250	$2,251	**$999**
	TruHearing Advanced	$2,720	$2,021	**$699**

Rechargeable battery option available on select styles for an additional $50 per hearing aid.
Exam must be performed by a TruHearing network provider.

Your hearing aid purchase includes

60-day, risk-free trial

1 year of follow-up visits

80 free batteries per non-rechargeable hearing aid

3-year full manufacturer warranty

Start by calling TruHearing.

1-833-731-4168 | TTY: 711

Hours: 8 a.m. to 8 p.m., Monday - Friday

TruHearing makes it easy.

Scan with your smartphone to see how it works.
TruHearing.com/how-it-works

1. Call 1-833-731-4168

2. Schedule an exam

3. Go to your exam

4. Order hearing aids

5. Fitting and follow-up

Call TruHearing to get started.

1-833-731-4168 | TTY: 711

Hours: 8 a.m. to 8 p.m., Monday - Friday

Screen your hearing: TruHearing.com/PresbyterianCOM-HS

Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but not limited to race, color, national origin, age, disability, or sexual orientation or gender expression. 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.

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.

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.

For more information, visit https://www.phs.org/nondiscrimination.

 Savings and retail pricing based on a survey of national average hearing aid prices of equivalent aids compared to TruHearing pricing. Actual savings may vary. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing Hearing Consultant. 639175-8-0425
MPC052535

KEEP MOVING WITH A FITNESS PASS MEMBERSHIP.

Only $29.50 per eligible member per month.

PRESBYTERIAN
Health Plan, Inc.

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

- Defined Fitness locations in Albuquerque, Rio Rancho, Farmington and Santa Fe
- Prime Fitness network (nationwide)
- A discount on Sports & Wellness gym fees

DEFINED FITNESS

www.defined.com

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

prime

www.primemember.com

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

SPORTS & WELLNESS

www.sportsandwellness.com

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

Fitness Pass program enrollment is easy. How to start:

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

- All enrolled health plan members aged 18 and older are eligible to enroll. Employees must enroll in the program for dependents to be eligible for the program.
- Once enrolled, Presbyterian will automatically debit your account or credit card each month.
- If you are a current Fitness Pass member, you will not need to renew your Fitness Pass gym membership each year. Your membership will automatically renew every December for the following year.
- Some gyms may charge a registration or annual fee.

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

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

Some things to keep in mind about your Fitness Pass membership

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

For information on Presbyterian Health Plan's Nondiscrimination Notice, go to **https://www.phs.org/nondiscrimination**.

Emergency Travel Assistance

Frequently Asked Questions

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

assist america
Innovative Assistance Solutions

When Should I Contact Assist America?
Contact Assist America, our global emergency assistance program provider, when you need to connect to qualified health care providers, hospitals, pharmacies and other services if you experience an emergency while traveling more than 100 miles away from home or outside the country for up to 90 days.

What information will I need to provide?

- Name, phone number, and relation to the member
- Member's name, age, and home address
- Description of emergency and current location
- Reference number

How do I contact Assist America?
You can contact Assist America's 24/7 Operations Center via:
Assist America Mobile App: Use the Tap for Help button to call or connect with the Operations Center using the Voice Over Internet Protocol feature.
Phone (Within US): 1-800-872-1414
Phone (Outside US): 609-986-1234
Email: medservices@assistamerica.com
Website: www.assistamerica.com

What costs are covered by Assist America?
Assist America arranges and pays for all of the transportation services provided. Assist America is not a medical insurer and does not pay for nor reimburse any medical expenses. Health claims should still be handled by your health insurance provider.

How can I download the app?
The Assist America Mobile App is available for free on the Apple App Store and Google Play. Once you have downloaded the app, enter Assist America reference number (**01-AA-PXI-10071**) to activate all the App's features. To turn the Coverage Indicator on, go to Set Up and enter your home address. This feature calculates your current distance from home. A highlighted status bar indicates when you are 100 miles away from home or in another country, thus eligible for services.

What if I plan on traveling for more than 90 days?
If you plan on traveling for more than 90 consecutive days, you can enroll in the Expatriate/Extended Program on the Assist America website at (www.assistamerica.com/expatriate) to enroll in the program and ensure coverage. The coverage will follow your active policy period.

MPC022405

Reference Number:

01-AA-PXI-10071

Download the Assist America Mobile App