

ENROLLMENT KIT

2027 SMALL GROUP PLANS

WE'RE DETERMINED TO PLAN FOR YOUR HEALTH.

PRESBYTERIAN

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

MPC092685

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.

SMALL GROUP PLANS

A HEALTH PLAN NEW MEXICANS CAN COUNT ON.

NEW FOR 2027

Gold Smart Choice EPO $3,500 w/Gym with Limited Service Area

The new Gold Smart Choice EPO $3,500 w/Gym with Limited Service Area Plan is designed to offer more affordable coverage in the five-county area while providing access to a broad national network. The Engage network will be used for care in New Mexico and the Aetna Network for care outside of New Mexico.

Silver Smart Choice EPO $4,000 w/Gym with Limited Service Area

The new Silver Smart Choice EPO $4,000 w/Gym with Limited Service Area Plan is designed to offer more affordable coverage in the five-county area while providing access to a broad national network. The Engage network will be used for care in New Mexico and the Aetna Network for care outside of New Mexico.

CONTINUING IN 2027

Plan Options with Engage Network

Seven plan options are available with gym benefits and a high-value subset of our HMO network providers. Each of these plans leverage the integrated relationship between our health plan and Presbyterian Medical Group and offer options for primary care, specialists, ancillary services such as laboratory and radiology, and facility-based services. Our Engage plans are designed for New Mexico employer groups in these counties: Bernalillo, Sandoval, Santa Fe, Valencia and Torrance. The Engage Network is a smaller network so we recommend you review the list of providers before selecting an Engage plan by visiting www.phs.org/engagesmallgroup.

Aetna Signature Administrators, PPO Network

Through a partnership with Aetna Signature Administrators, Aetna's PPO network offers access to more than 1.5 million participating physicians and ancillary providers, including over 6,000 hospitals. This means you can access some Out-of-Network services when using Aetna contracted providers.

To receive a full schedule of benefits, limitations or exclusions, contact your health insurance broker or your Presbyterian Sales Account Manager.

PRESBYTERIAN

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

PRESBYTERIAN
Health Plan, Inc.

2027 Small Group HMO Overview

HMO Benefits	Platinum Elite $250 w/Gym	Gold Elite $1,000 w/Gym	Gold Premier $3,500 w/Gym	Silver $3,500 Advantage HDHP/HSA w/Gym*	Silver Premier $4,000 w/Gym
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$250 / $500	$1,000 / $2,000	$3,500 / $7,000	$3,500 / $7,000	$4,000 / $8,000
What do I pay for covered benefits?	**Copayment – Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and or coinsurance.** Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**				
Preventive Care	You pay $0 (in-network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy, and routine immunizations.				
Primary Care Provider Visit	$20	$40	$40	$40 with ded	$40
Urgent Care	$20	$40	$40	$40 with ded	$40
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$40	$90	$90	$50 with ded	$90
Mental Health Outpatient Services	No charge	No charge	No charge	No charge after ded	No charge
Lab	No charge	No charge	No charge	$50 with ded	$50
X-ray	No charge	No charge	No charge	$50 with ded	$100
Imaging CT/PET/MRI	$500	$750	$750	20%	$750
Emergency Room Plans with copay ($) all services are included	$750	$1,200	$1,000	$750 with ded	$1,200
Ambulance Ground or Air	$250	$250	$250	20%	$250
Hospital Inpatient or Outpatient	20%	20%	20%	20%	30%
Chiropractic and Acupuncture Limited to 20 visits each	$20	$40	$40	$40 with ded	$40
Rehabilitation Therapy Physical, Occupational and Speech	$20	$40	$40	$40 with ded	$40
Prescription Drugs per 30-day supply					
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge after ded	No charge
Tier 2: Non-Preferred Generic	$5	$5	$5	$15 with ded	$25
Tier 3: Preferred Brand	$15	$15	$15	$50 with ded	$50
Tier 4: Non-Preferred Brand	$100	$100	$100	$100 with ded	$100
Tier 5: Specialty Pharmaceuticals	50%	50%	50%	20%	30%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay					
The family out-of-pocket maximum is 2x the individual out-of-pocket maximum.	$5,500 / $11,000	$12,000 / $24,000	$8,500 / $17,000	$8,000 / $16,000	$12,000 / $24,000
Wellness and Other Services					
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.				
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)				
Dental	We have partnered with BenefitSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)				
The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-356-2219 or refer to the Group Subscriber Agreement and/or Summary of Benefits and Coverage, which can be found online at www.phs.org/formsanddocuments.					

*__High Deductible Health Plans (HDHP)__ - Qualified High Deductible Health Plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity, you can conveniently open an HSA to pay for your insurance deductible and qualified Out-of-pocket medical expenses tax-free. To learn more, visit **www.healthequity.com** or call **1-866-346-5800**.

** Except for Silver $3,500 Advantage HDHP/HSA w/Gym. Copayments will not apply until the deductible has been met.

Effective: January 1, 2027

PRESBYTERIAN
Insurance Company, Inc.

2027 Small Group PPO Overview

PPO Benefits	Platinum Elite $250 w/Gym	Gold Elite $1,000 w/Gym	Gold Premier $3,500 w/Gym	Silver $3,500 Advantage HDHP/HSA w/Gym*	Silver Premier $4,000 w/Gym
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$250 / $500	$1,000 / $2,000	$3,500 / $7,000	$3,500 / $7,000	$4,000 / $8,000
Coinsurance	20% / 50%	20% / 50%	20% / 50%	20% / 50%	30% / 50%
What do I pay for covered benefits?	**Copayment – Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and or coinsurance.** Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**				
Preventive Care	You pay $0 (in-network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy, and routine immunizations.				
Primary Care Provider Visit	$20	$40	$40	$40 with ded	$40
Urgent Care	$20	$40	$40	$40 with ded	$40
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$40	$90	$90	$50 with ded	$90
Mental Health Outpatient Services	No charge	No charge	No charge	No charge after ded	No charge
Lab	No charge	No charge	No charge	$50 with ded	$50
X-ray	No charge	No charge	No charge	$50 with ded	$100
Imaging CT/PET/MRI	$500	$750	$750	20%	$750
Emergency Room Plans with copay ($) all services are included	$750	$1,200	$1,000	$750 with ded	$1,200
Ambulance Ground or Air	$250	$250	$250	20%	$250
Hospital Inpatient and Outpatient	20%	20%	20%	20%	30%
Chiropractic and Acupuncture Limited to 20 visits each	$20	$40	$40	$40 with ded	$40
Rehabilitation Therapy Physical, Occupational and Speech	$20	$40	$40	$40 with ded	$40
Prescription Drugs per 30-day supply					
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge after ded	No charge
Tier 2: Non-Preferred Generic	$5	$5	$5	$15 with ded	$25
Tier 3: Preferred Brand	$15	$15	$15	$50 with ded	$50
Tier 4: Non-Preferred Brand	$100	$100	$100	$100 with ded	$100
Tier 5: Specialty Pharmaceuticals	50%	50%	50%	20%	30%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance, and prescription drug costs that you pay.					
The family out-of-pocket maximum is 2x the individual out-of-pocket maximum.	$5,500 / $11,000	$12,000 / $24,000	$8,500 / $17,000	$8,000 / $16,000	$12,000 / $24,000
Wellness and Other Services					
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.				
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)				
Dental	We have partnered with BenefitSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)				
The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-923-6980 or refer to the Group Subscriber Agreement and/or Summary of Benefits and Coverage, which can be found online at www.phs.org/formsanddocuments.					

***High Deductible Health Plans (HDHP)** - Qualified High Deductible Health Plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity, you can conveniently open an HSA to pay for your insurance deductible and qualified out-of-pocket medical expenses tax-free. To learn more, visit **www.healthequity.com** or call **1-866-346-5800**.

** Except for Silver $3,500 Advantage HDHP/HSA w/Gym. Copayments will not apply until the deductible has been met.

Effective: January 1, 2027

PRESBYTERIAN
Health Plan, Inc.

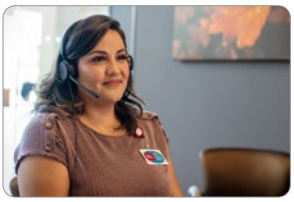
2027 Small Group Engage Overview

Engage Benefits	Platinum Engage $500 w/Gym with Limited Service Area	Gold Engage $1,500 w/Gym with Limited Service Area	Gold Smart Choice EPO $3,500 w/Gym with Limited Service Area	Silver Smart Choice EPO $4,000 w/Gym with Limited Service Area	Silver Engage $4000 w/Gym with Limited Service Area	Silver Engage $7,000 w/ Gym with Limited Service Area	Silver Engage $0 w/Gym with Limited Service Area
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$500 / $1,000	$1,500 / $3,000	$3,500 / $7,000	$4,000 / $8,000	$4,000 / $8,000	$7,000 / $14,000	$0 / $0
What do I pay for covered benefits?	**Copayment-Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and/or coinsurance. Coinsurance-Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**						
Preventive Care	You pay $0 (in-network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy and routine immunizations.						
Primary Care Provider Visit	$10	$40	$40	$40	$40	$40	$50
Urgent Care	$10	$40	$40	$40	$40	$40	$50
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$40	$90	$90	$90	$90	$90	$100
Mental Health Outpatient Services	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Lab	No charge	No charge	No charge	$50	$50	$50	$100
X-ray	No charge	No charge	No charge	$100	$100	$100	$100
Imaging CT/PET/MRI	$500	$500	$750	$750	$900	$500	30%
Emergency Room Plans with copay ($) all services are included	$1,000	$750	$1,000	$1,200	$900	30%	$1,850
Ambulance Ground or Air	$250	$250	$250	$250	$250	$250	$250
Hospital Inpatient or Outpatient	20%	20%	20%	30%	30%	30%	$1,500 per day, 2-day max
Chiropractic and Acupuncture Limited to 20 visits each	$10	$40	$40	$40	$40	$40	$50
Rehabilitation Therapy Physical, Occupational and Speech	$10	$40	$40	$40	$40	$40	$50
Prescription Drugs per 30-day supply							
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Tier 2: Non-Preferred Generic	$5	$5	$5	$25	$25	$25	$25
Tier 3: Preferred Brand	$15	$15	$15	$50	$75	$50	$50
Tier 4: Non-Preferred Brand	$100	$100	$100	$100	$150	30%	$125
Tier 5: Specialty Pharmaceuticals	50%	50%	50%	30%	50%	30%	50%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay							
The family out-of-pocket maximum is 2x the individual out-of-pocket maximum.	$4,500 / $9,000	$12,000 / $24,000	$8,500 / $17,000	$12,000 / $24,000	$12,000 / $24,000	$12,000 / $24,000	$12,000 / $24,000
Wellness and Other Services							
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.						
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)						
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Effective: January 1, 2027

MEMBER RESOURCES

Local customer service



Our representatives, located in Albuquerque, are standing by to answer your benefit questions Monday through Friday from 8 a.m. to 5 p.m. Contact our Presbyterian Customer Service Center by calling **(505) 923-5678** or **1-800-356-2219 (TTY 711)**, or emailing **info@phs.org**.

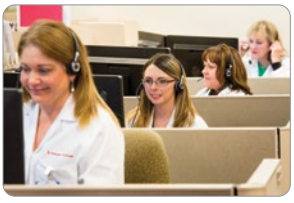
myPRES



Get the information you want when you need it. Presbyterian's web-based services offer fast and convenient service any day of the year. To sign in or register, visit **phs.org/myPRES**. Please use your primary personal email address when registering to ensure you receive important information and notifications.

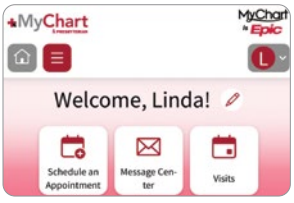
- Look up benefit information securely, view a claim's status and track deductibles.
- Estimate out-of-pocket costs for common medical treatments and procedures with a Treatment Cost Estimator.
- View or request a replacement member ID card.
- Use myPRES to schedule appointments, including telehealth visits.

PresRN Nurse Advice Line



Speak with a Presbyterian registered nurse for medical advice at no cost, 24 hours a day, every day, including holidays by calling **(505) 923-5570** or **1-866-221-9679**. For more information, visit **phs.org** and search for "PresRN."

MyChart



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

Seeking care in New Mexico?

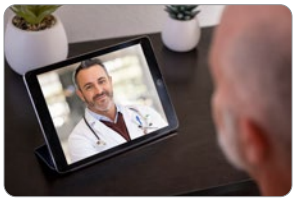


Create a personalized provider directory for providers who are close to work or home, find specific providers (including primary and specialty care providers), narrow the search to match preferences (such as a male or female provider), and find facilities and pharmacies. Visit **phs.org/directory**. The Engage Network includes a smaller selection of providers, so please review the provider list carefully at **phs.org/engagesmallgroup** before choosing an Engage plan.

Seeking care outside of New Mexico?

PPO members only receive In-Network benefits outside of New Mexico through our partnership with Aetna. Refer to your Summary of Benefits and Coverage (SBC) to see if your plan qualifies. View provider directory at **aetna.com/asa**.

Virtual Care



See a provider anytime, day or night. This option offers a new way to see a medical provider for nonemergency medical conditions via secure video through a smartphone, tablet or computer webcam. Visits are $0. (Costs may apply for High Deductible Health Plan members). For details, visit **phs.org/virtualpres**.

PresNow

Albuquerque's only 24/7 emergency and urgent care under one roof. Patients don't have to guess if it's an emergency because medical staff decide the level of care needed. Visit **PRESNow247.org** to learn more.

Mail-Order Pharmacy Service

Provided by Costco Pharmacy, our mail-order pharmacy benefit allows you to order up to a 90-day supply of maintenance prescriptions (as prescribed by a provider) and have them conveniently delivered to a specified address. Please register at **rx.costco.com** If you already have a Costco Pharmacy account, there is no need to re-register.

MEMBER RESOURCES

Employee Assistance Program (EAP)

The Solutions Group

Confidential support for complex personal challenges. Learning how to cope with stress at work and at home can improve overall well-being. Members and families living in the same household can get up to six complimentary assistance visits per situation. Services are short-term, confidential counseling sessions conducted by local licensed providers. To schedule an appointment with an EAP counselor, please call **(505) 254-3555** or **1-866-254-3555**.

Disclaimer: Value added products and services are not insurance benefits and may be discontinued at any time.

Wellness at Work

WELLNESS AT WORK

Through this online program, you can access all your wellness tools and create a personalized health improvement plan. It features a Personal Health Assessment (PHA) tool to help identify personal health risks and provide recommendations for improving those risks.
To participate, visit **phs.org** and register or log onto myPRES.

Disclaimer: Value-added products and services are not insurance benefits and may be discontinued at any time.

Talkspace

talkspace

Messaging therapy offers members age 14 and older behavioral health coaching with licensed behavioral therapists via text, video or audio messaging at a time and place that is convenient for them. Go to **www.talkspace.com/php** to access the program.

Disclaimer: Value-added products and services are not insurance benefits and may be discontinued at any time.

Vision Coverage



Presbyterian offers vision coverage options for the entire family for an additional monthly premium. Vision for Children is included with your medical plan. For costs and complete details of coverage or for more information, please call us Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-5807**.

Estimate Your Cost of Care

Now you can better evaluate the cost of certain tests and procedures with our new Treatment Cost Estimator. This tool will provide estimates for many of your covered services and help you find convenient locations to obtain care that may lower costs. Visit **phs.org/tools-resources/member/applicable-rates** for details.

Sword

sword

Sword is an AI physical therapy solution for back, joint and muscle pain. Members will be invited to participate and register by visiting phs.org and registering for a myPRES account and logging into the Sword tool as soon as they enroll on a plan with Presbyterian. For details, visit **sword.health/thrive/presbyterian/go**.

Assist America

assist america®

You have the protection of Assist America's global emergency travel assistance services 24 hours a day, 365 days a year. This unique program immediately connects you to services when experiencing a medical emergency while traveling 100 miles or more away from a permanent residence or in another country. First, download the free Assist America Mobile App, then log in with reference number 01-AA-PXI-10071. For questions, contact Assist America's Operations Center at **1-800-872-1414** (or +1-609-986-1234 outside of the USA).

Disclaimer: Value-added products and services are not insurance benefits and may be discontinued at any time.

TruHearing

TruHearing

With copayments as low as $699 per hearing aid, this benefit makes addressing hearing loss more affordable. Call TruHearing to learn more and schedule an appointment at **1-833-731-4167** (TTY 711), Monday through Friday, 8 a.m. to 8 p.m.

Disclaimer: Value-added products and services are not insurance benefits and may be discontinued at any time.

MEMBER RESOURCES

Value-Added Program

Members are automatically enrolled in the BenefitSource Value-Added program, which provides supplemental vision and hearing programs, complementary and alternative medicine, wellness and discounts for services such as light housekeeping, general custodial care and companionship. For more information, contact BenefitSource at **1-888-862-8659** or visit **www.benefitsource.org/presbyterian**.

Disclaimer: Value-added products and services are not insurance benefits and may be discontinued at any time.

Dental Coverage



Presbyterian and BenefitSource have also partnered to offer you six PPO dental coverage options, each offering you lower Out-of-Pocket costs when obtaining dental care within the network. You are also covered when obtaining dental care from non-participating providers. For more information, contact BenefitSource at **1-888-862-8659** or visit **www.benefitsource.org**.

HealthEquity

Through our partnership with HealthEquity, employers can elect to offer a qualified High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) at no additional cost. HealthEquity also offers Health Reimbursement Account (HRA) and Flexible Spending Account (FSA) options to members at a reduced cost. Call 1-866-346-5800 or visit **www.healthequity.com**.

Disclaimer: Value added products and services are not insurance benefits and may be discontinued at any time.

Trualta

Trualta is a caregiver support platform, available 24/7 at no cost, that provides access to education and online community resources. Trualta offers one-on-one personalized coaching, online support groups and chat rooms, and practical education that is available in both English and Spanish. For details, visit **phs.org/tools-resources/member/caregiver-support**.

Fitness/Gym Membership

You and your enrolled dependents (ages 18 and older) can enjoy no-cost access to more than 10,000 national, regional and local fitness, recreation and community centers. These facilities include all Defined Fitness locations in Albuquerque, Rio Rancho, Farmington and Santa Fe, as well as the nationwide Prime® Fitness network which includes select YMCA locations, Snap Fitness, Chuze, Curves and more. Discounted rates are also available from Genesis Health Clubs. For a list of participating locations, visit **phs.org/gymmembership**.

Disclaimer: Value-added products and services are not insurance benefits and may be discontinued at any time.

*This policy has some exclusions and limitations. For costs and complete details of the coverage, call or write your insurance agent or contact our Presbyterian Customer Service Center by calling (505) 923-5678 or 1-800-356-2219 (TTY 711), or emailing **info@phs.org**.*

HealthEquity®

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

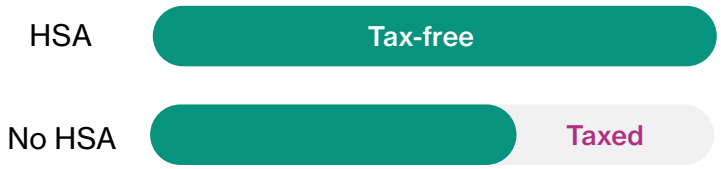
Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:[1] Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- Rolls over every year – funds never expire
- Available tax-free investing, just like a 401(k)[2]
- Requires an eligible high-deductible health plan (HDHP)

Less tax. More paycheck.

Get $20 tax savings for every $100 you contribute.[3]



2027 HSA Contribution Limits

$4,500 Individual plan

$9,000 Family plan

Members 55+ can contribute an extra $1,000

HealthEquity.com/Presbyterian

Scan to download the HealthEquity mobile app.



You can set up your account directly in the app – no need to register online.

Spend tax-free on HSA-qualified expenses.

- Medical
- Dental
- Vision
- Rx and OTC

Discover more: HealthEquity.com/QME

Enrollment period

Small groups can enroll at any time of year and do not have to wait for a renewal date.
(505) 923-5807

HSA-qualified health plan options

Silver $3,500 Advantage HDHP/HSA Plan w/Gym

*2026 IRS Contribution Limits: https://www.irs.gov/pub/irs-drop/n-26-05.pdf
Value-added products and services are not insurance benefits and may be discontinued at any time. This policy has exclusions and/or limitations. For costs and complete details of the coverage, call Presbyterian Health Plan. Value-added products and services are not insurance benefits and may be discontinued at any time.

[1]HSAs are federally tax-deductible for qualified medical expenses and usually state-deductible; consult a tax advisor for details. | [2]Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. | [3]Example for illustration only; savings based on a 30% federal and state tax bracket. | HealthEquity does not provide legal, tax or financial advice.

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Companion Life

This is an outline of Dental Insurance Coverage underwritten by Companion Life Insurance Company.

Dental Insurance Benefit Summary

Standard Option	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
Class I: Diagnostic/Preventive Services • Oral Examinations • Cleanings • Fluoride Treatment • Space Maintainers • Sealants • Palliative Emergency Treatment • Dental X-rays	0%	10% MAC*
Class II: Basic Services • Oral Surgery • Extractions • Restorations (composite white and silver fillings) • Anesthesia (in conjunction with oral surgery) • Endodontic Services • Periodontal Services	20%	40% MAC*
Class III: Major Services • Crowns • Bridges • Dentures • Inlays • Other Prosthetic Services • Implants	50%	60% MAC*
Class IV: Orthodontia Services No Waiting Period	N/A	N/A
Covered Expenses	Percentage of coverage is paid at the pre-negotiated fees.	*Maximum Allowable Charge (MAC)
Maximum Benefit per contract year for all Class I, III and III expenses.	$1,500 per person	
Deductible applicable to Class II and III covered expenses. *Deductible is based on contract year with a maximum of three (3) deductibles per family ($150)*	$50 per person	

Monthly Premium

4 Tier

Employee	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
$ 26.18	$ 56.44	$ 54.59	$ 82.90

Rates effective 01/01/27

The above provides only a brief description of your dental insurance plan. Please refer to the policy for complete details including limitations and exclusions. For more information, please contact BenefitSource toll free at 888-862-8659.

Visit our website at **BenefitSource.org** for a current list of PPO providers in your area.

BenefitSource

Marketed by BenefitSource, Inc.

1804 Juan Tabo NE, Suite A, Albuquerque, NM 87112

Telephone 505-237-1501 or 888-862-8659

505-237-8344 Fax

These benefits are provided by Policy Form No. CL-DEN-1100-P-NM.

Learn more about Companion Life's Nondiscrimination Notice and Foreign Language Access – http:/www.companionlife.com/non-discrimination-statement

Companion Life

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Dental Insurance Benefit Summary

Standard Child Ortho	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
Class I: Diagnostic/Preventive Services • Oral Examinations • Cleanings • Fluoride Treatment • Space Maintainers • Sealants • Palliative Emergency Treatment • Dental X-rays	0%	10%
Class II: Basic Services • Oral Surgery • Extractions • Restorations (composite white and silver fillings) • Anesthesia (in conjunction with oral surgery) • Endodontic Services • Periodontal Services	20%	40%
Class III: Major Services • Crowns • Bridges • Dentures • Inlays • Other Prosthetic Services • Implants	50%	60%
Class IV: Orthodontia Services No Waiting Period	50%	50%
Covered Expenses	Percentage of coverage is paid at the pre-negotiated fees.	Percentage of coverage is paid based on the 90th percentile usual and customary rates (UCR)
Maximum Benefit per contract year for all Class I, III and III expenses.	$1,500 per person	
Orthodontic Lifetime Maximum Benefit for Dependent Child(ren) up to age 19	$1,000 per person	
Deductible applicable to Class II and III covered expenses. *Deductible is based on contract year with a maximum of three (3) deductibles per family ($150)*	$50 per person	

Monthly Premium

4 Tier

Employee	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
$ 26.18	$ 56.44	$ 61.14	$ 92.85

Rates effective 01/01/27

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Dental Insurance Benefit Summary

Standard Adult/Child Ortho	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
Class I: Diagnostic/Preventive Services • Oral Examinations • Cleanings • Fluoride Treatment • Space Maintainers • Sealants • Palliative Emergency Treatment • Dental X-rays	0%	10%
Class II: Basic Services • Oral Surgery • Extractions • Restorations (composite white and silver fillings) • Anesthesia (in conjunction with oral surgery) • Endodontic Services • Periodontal Services	20%	40%
Class III: Major Services • Crowns • Bridges • Dentures • Inlays • Other Prosthetic Services • Implants	50%	60%
Class IV: Orthodontia Services No Waiting Period	50%	50%
Covered Expenses	Percentage of coverage is paid at the pre-negotiated fees.	Percentage of coverage is paid based on the 90th percentile usual and customary rates (UCR)
Maximum Benefit per contract year for all Class I, III and III expenses.	$1,500 per person	
Orthodontic Lifetime Maximum Benefit for Adults and Dependent Child(ren)	$1,000 per person	
Deductible applicable to Class II and III covered expenses. *Deductible is based on contract year with a maximum of three (3) deductibles per family ($150)*	$50 per person	

Monthly Premium

4 Tier

Employee	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
$ 27.82	$ 59.87	$ 64.69	$ 98.21

Rates effective 01/01/27

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BenefitSource

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Dental Insurance Benefit Summary

High Option	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
Class I: Diagnostic/Preventive Services • Oral Examinations • Cleanings • Fluoride Treatment • Space Maintainers • Sealants • Palliative Emergency Treatment • Dental X-rays	0%	10% MAC*
Class II: Basic Services • Oral Surgery • Extractions • Restorations (composite white and silver fillings) • Anesthesia (in conjunction with oral surgery) • Endodontic Services • Periodontal Services	20%	20% MAC*
Class III: Major Services • Crowns • Bridges • Dentures • Inlays • Other Prosthetic Services • Implants	50%	50% MAC*
Class IV: Orthodontia Services No Waiting Period	N/A	N/A
Covered Expenses	Percentage of coverage is paid at the pre-negotiated fees.	*Maximum Allowable Charge (MAC)
Maximum Benefit per contract year for all Class I, III and III expenses.	$2,000 per person	
Deductible applicable to Class II and III covered expenses. *Deductible is based on contract year with a maximum of three (3) deductibles per family ($150)*	$50 per person	

Monthly Premium

4 Tier

Employee	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
$ 32.73	$ 73.05	$ 67.22	$ 99.88

Rates effective 01/01/27

The above provides only a brief description of your dental insurance plan. Please refer to the policy for complete details including limitations and exclusions. For more information, please contact BenefitSource toll free at 888-862-8659.
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Telephone 505-237-1501 or 888-862-8659
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BenefitSource

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Companion Life

This is an outline of Dental Insurance Coverage underwritten by Companion Life Insurance Company.

Dental Insurance Benefit Summary

High Child Ortho	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
Class I: Diagnostic/Preventive Services • Oral Examinations • Cleanings • Fluoride Treatment • Space Maintainers • Sealants • Palliative Emergency Treatment • Dental X-rays	0%	10%
Class II: Basic Services • Oral Surgery • Extractions • Restorations (composite white and silver fillings) • Anesthesia (in conjunction with oral surgery) • Endodontic Services • Periodontal Services	20%	20%
Class III: Major Services • Crowns • Bridges • Dentures • Inlays • Other Prosthetic Services • Implants	50%	50%
Class IV: Orthodontia Services No Waiting Period	50%	50%
Covered Expenses	Percentage of coverage is paid at the pre-negotiated fees.	Percentage of coverage is paid based on the 90th percentile usual and customary rates (UCR)
Maximum Benefit per contract year for all Class I, III and III expenses.	$2,000 per person	
Orthodontic Lifetime Maximum Benefit for Dependent Child(ren) up to age 19	$1,500 per person	
Deductible applicable to Class II and III covered expenses. *Deductible is based on contract year with a maximum of three (3) deductibles per family ($150)*	$50 per person	

Monthly Premium

4 Tier

Employee	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
$ 32.73	$ 73.05	$ 75.29	$ 111.87

Rates effective 01/01/27

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NM

Learn more about Companion Life's Nondiscrimination Notice and Foreign Language Access – http:/www.companionlife.com/non-discrimination-statement

Companion Life

This is an outline of Dental Insurance Coverage underwritten by Companion Life Insurance Company.

Dental Insurance Benefit Summary

High Adult/Child Ortho	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
Class I: Diagnostic/Preventive Services • Oral Examinations • Cleanings • Fluoride Treatment • Space Maintainers • Sealants • Palliative Emergency Treatment • Dental X-rays	0%	0%
Class II: Basic Services • Oral Surgery • Extractions • Restorations (composite white and silver fillings) • Anesthesia (in conjunction with oral surgery) • Endodontic Services • Periodontal Services	20%	20%
Class III: Major Services • Crowns • Bridges • Dentures • Inlays • Other Prosthetic Services • Implants	50%	50%
Class IV: Orthodontia Services No Waiting Period	50%	50%
Covered Expenses	Percentage of coverage is paid at the pre-negotiated fees.	Percentage of coverage is paid based on the 90th percentile usual and customary rates (UCR)
Maximum Benefit per contract year for all Class I, III and III expenses.	$2,000 per person	
Orthodontic Lifetime Maximum Benefit for Adults and Dependent Child(ren)	$1,500 per person	
Deductible applicable to Class II and III covered expenses. *Deductible is based on contract year with a maximum of three (3) deductibles per family ($150)*	$50 per person	

Monthly Premium

4 Tier

Employee	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
$ 35.02	$ 78.16	$ 80.56	$ 119.70

Rates effective 01/01/27

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Visit our website at **BenefitSource.org** for a current list of PPO providers in your area.

BenefitSource

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505-237-8344 Fax

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Learn more about Companion Life's Nondiscrimination Notice and Foreign Language Access – http:/www.companionlife.com/non-discrimination-statement

DENTAL by Design

This is an outline of Dental Insurance Coverage underwritten by Companion Life Insurance Company.

Exclusions – Dental Insurance

Covered Expenses will not include and no benefits will be payable for the following:

- Expenses in any Class of services that are incurred during the Insured's waiting period for services in that Class (as shown in the Schedule of Benefits), except as may be provided under the Takeover Provisions provision. An Insured is not eligible for Takeover Provisions if Takeover Provisions are not provided, or if Takeover Provisions are provided but the person:
    - is a Late Entrant;
    - became insured under the Policy after the Employer's Effective Date; or
    - was not insured under the Employer's prior plan that was replaced by coverage under the Policy.
- Any treatment which is for cosmetic purposes, or to correct congenital malformations, other than Medically Necessary treatment of congenital cleft in the lip or palate, or both.
- Initial placement of any full or partial denture, implants, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such placement is needed because of the extraction of one or more of the Insured's natural teeth during the same period of continuous coverage. Any portion of the expense that is identifiable as applying specifically to the replacement of a tooth extracted before that period of continuous coverage is not a Covered Expense. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment. Any such appliance must include the replacement of the extracted tooth or teeth.
- Replacement of any full or partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration within 5 years of the date of the last placement of the item. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under the Policy, it will be a Covered Expense. In any event, replacement is not a Covered Expense if the item can instead be repaired or otherwise restored to adequate function.
- Replacement of an existing implant and/or supported prosthetic device is covered only once every 10 years from the placement date of such device and only then if it is unserviceable and cannot be made serviceable. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under the Policy, it will be a Covered Expense. In any event, replacement is not a Covered Expense if the item can instead be repaired or otherwise restored to adequate function.
- Addition of a new tooth or teeth to an existing full or partial denture, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such addition is a replacement of a natural tooth or teeth extracted during the same period of continuous coverage. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment.
- Any expense incurred before the Insured's insurance under the Policy starts; or any expense incurred during any period of continuous coverage for the Insured under the Policy if the procedure starts before the period of continuous coverage starts.
- Any procedure that starts, or any expense that is incurred (regardless of when the procedure starts), after the Insured's insurance under the Policy ends. But this exclusion does not apply for any denture, partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration if both:
    - the procedure starts while the Insured's insurance under the Policy is in effect; and
    - the expense is incurred within 90 days after the Insured's insurance under the Policy ends.
- Duplication of appliances, or replacement of lost or stolen appliances.
- Appliances, restorations, or procedures to:
    - alter vertical dimension;
    - restore or maintain occlusion;
    - splint or replace tooth structure lost as a result of abrasion or attrition; or
    - treat jaw fractures or disturbances of the temporomandibular joint.
- Any procedure that is not shown on the list of Covered Dental Expense Procedures.
- Education or training in, or supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
- Charges for broken appointments or the completion of claim forms.
- Root planing (procedure numbers D4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
- Charges because of an Insured's injury arising out of, or in the course of, work for wage or profit.
- Charges because of an Insured Individual sickness, injury, or condition for which he or she is eligible for benefits under any workers' compensation act or similar laws.
- Charges for which the Insured Individual is not liable or which would not have been made had no insurance been in force.
- Services that:
    - are not recommended by a Dentist;
    - are not required for necessary care and treatment; or
    - do not have a reasonably favorable prognosis.
- Charges because of an Insured's sickness, injury, or other condition due to war or any act of war, declared or not, or sustained while on full-time active duty in the armed forces of any country.
- Benefits payable to an Insured Individual if payment is not legal where the Insured Individual is living when expenses are incurred.
- Services related to: equilibration; bite registration or bite analysis.
- Crowns for the purpose of periodontal splinting.
- Charges for overdentures, precision or semi-precision attachments and associated endodontic treatment, any other customized attachments,

This Benefits Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

Companion Life

P.O. Box 100102 | Columbia, SC 29202-3102
800-753-0404 | 800-836-5433 fax
CompanionLife.com

These benefits are provided by Policy Form No. CL-DEN-1100-P-NM.

or any specialized prosthodontic techniques or characterizations.
- Charges for: myofunctional therapy, orthognathic surgery, or athletic mouthguards.
- Implant or implant services where loss of the tooth was prior to the Insured Individual's Effective Date of coverage under the Policy.
- Procedures for which benefits are payable under the Employer's medical expense benefit plan for Employees and their Dependents. See the Coordination of Benefits provision for an explanation.
- Services rendered by the Insured's Spouse, parent, parent-in-law, brother or sister, brother-in-law or sister-in-law, child (of the Insured or the Insured's Spouse), or any person residing in the Insured's household.

95813_BS Dental_STD_No_OrthoRev. 01/01/2027
95813_BS Dental_STD_Child_OrthoRev. 01/01/2027
95813_BS Dental_STD_Adult_OrthoRev. 01/01/2027
95813_BS Dental_High_No_OrthoRev. 01/01/2027
95813_BS Dental_High_Child_OrthoRev. 01/01/2027

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DETERMINED TO SUPPORT YOUR EYE HEALTH.

PRESBYTERIAN
Insurance Company, Inc.

Clear Vision by Presbyterian, vision coverage for your entire family.

PLAN FEATURES

Large and diverse network

- Ability to purchase eyewear from online retailers including Glasses.com™, 1-800 Contacts®, Befitting, Warby Parker and Visionworks®
- Out-of-network reimbursement

Benefits that are easy to use and understand

- Members can check benefits, eligibility, search for eyecare professionals and track frame status through a convenient mobile app and online through the member portal
- A new estimator tool for members at versanthealth.com/estimator

Find an eyecare professional at davisvision.com/presbyterian, then schedule your eye exam today!

This policy has limitations and/or exclusions. For costs and complete details of the coverage or for more information, please call us Monday through Friday from 8 a.m. to 5 p.m. at (505) 923-5807.

CLEAR VISION BY PRESBYTERIAN PLAN OPTIONS

Clear Vision is underwritten by Presbyterian Insurance Company, Inc. and administered by Davis Vision.

In-Network Benefits	CORE	CLASSIC	COMPLETE	SIGNATURE
Frequencies				
Eye exam	12 months	12 months	12 months	12 months
Spectacle lenses	12 months	12 months	12 months	12 months
Frame	12 months	24 months	24 months	24 months
Contact lens evaluation, fitting and follow-up care	12 months	12 months	12 months	12 months
Copayments				
Eye exam	$0 copay	$10	$10	$0
Spectacle lenses	Single vision $45 Bifocal $65 Trifocal $95 Lenticular $120	$25	$15	$10
Contact lens evaluation, fitting and follow-up care	N/A	$0	$15	$10
Coverage				
Frame allowance (retail):	35% off provider's U&C (usual & customary)	Up to $130, plus 20% discount on any overages	Up to $150, plus 20% discount on any overages	Up to $180, plus 20% discount on any overages
Additional discounts and coverage available at Visionworks® and for Davis Vision collections. Visit Davis Vision at www.davisvision.com.				
Contact lenses: materials allowance	15% off provider's U&C (usual & customary)	Up to $130, plus 15% discount on any overages	Up to $150, plus 15% discount on any overages	Up to $180, plus 15% discount on any overages
Laser Benefit				
One-time/lifetime allowance	N/A	$200	$200	$200
Eyeglass Benefit – Spectacle Lenses				
Digital single vision (intermediate)	$30	$30	$30	$30
Scratch-resistant coating	$15	$0	$0	$0
Polycarbonate lenses (child/adult)	$35	$0 or $30	$0 or $30	$0 or $30
Standard anti-reflective (AR) coating	$45	$35	$35	$35
Standard progressive lenses	$65	$50	$50	$50
Out-of-Network Reimbursements				
Eye exam	$50	$45	$45	$55
Frame	$50	$64	$64	$88
Single vision lenses	N/A	$40	$40	$40
Bifocal vision lenses	N/A	$60	$60	$60
Progressive lenses	N/A	N/A	N/A	$38

The benefit information provided is a brief summary, not a comprehensive description of all benefits, limitations and/or exclusions. For more information, call 1-800-999-5431 or refer to the plan information at davisvision.com.

NEXT STEPS TO SMALL GROUP ENROLLMENT

Small groups can enroll at any time of year and do not have to wait for a renewal date.

1. To ensure timely processing and receipt of Premium Billing invoices and ID cards prior to your requested effective date, please complete the three-page **Employer Group Information Application** by these deadlines:
   - **1st of the month effective date** - Completed applications must be received by the 15th of the previous month (e.g. by May 15th for a June 1st effective date).
   - **15th of the month effective date** - Completed applications must be received by the last day of the month (e.g. May 31st for a June 15th effective date).
2. If you select optional dental and/or vision coverage, please include the following completed forms:
   - Companion Life Group Dental Policy Application
   - Companion Life Group Dental Employee Enrollment Form
   - Companion Life Plan Benefit Summary of your choice (Signed and Dated)
   - Clear Vision by Presbyterian Application and Agreement
   - Clear Vision by Presbyterian Group Member Enrollment Form
   - Presbyterian Application

   This option is available for groups with a minimum of two contracts.
3. Complete an Employee Action Form for each employee enrolling in a health plan.
4. Sign and date the first page of the Group Letter of Agreement.
5. Scan and email the following completed forms to PresSmallGroupSales@phs.org or fax to a Presbyterian Account Executive at (505) 923-8225.
   - Employer Group Information Application
   - Companion Life/BenefitSource Application (optional)
   - Companion Life Group Dental Employee Enrollment Form (optional)
   - Companion Life Plan Benefit Summary of your choice (Optional, Signed and Dated)
   - Clear Vision by Presbyterian Application and Agreement (optional)
   - Clear Vision by Presbyterian Group Member Enrollment Form (optional)
   - Employee Action Forms
   - Page 1 of the Group Letter of Agreement

Employer Group Information Application

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

Application Instructions

1. Get help with this application by calling us at **(505) 923-5807** (TTY 711), Monday through Friday, 8 a.m. to 5 p.m. Additional forms may be found online at **www.phs.org/employers**.
2. Complete this form and fax it to **(505) 923-8225** or email it to your account executive.

Step 1 – Employer Group Information

REQUESTED EFFECTIVE DATE (MM/DD/YYYY):

Group name:		Tax identification number:	
Group legal name (if different than above):			
Group contact name:	Group contact title:	Billing contact name:	Billing contact title:
Group contact phone:		Billing contact phone:	
Group contact email:		Billing contact email:	
Physical address (P.O. Boxes are not allowed):			Suite number:
City:	State:	ZIP code:	County:
Billing address (if different from physical address):			Suite number:
City:	State:	ZIP code:	County:

Is this company affiliated with any other companies? Yes ☐ No ☐ If yes, affiliation's name:

Was group previously enrolled with Presbyterian? Yes ☐ No ☐ If yes, group name/number:

Step 2 – Eligibility and Contribution Guidelines

Waiting Period:

Date of hire

☐ First of the month following date of hire

☐ First of the month following 30 days of employment

☐ First of the month following 60 days of employment

☐ Effective on the 91st date of employment

Eligibility:

1. Part-time employment applies to the waiting period?
   Yes ☐ No ☐
2. Group agrees to domestic partner coverage?
   Yes ☐ No ☐
3. Group is COBRA eligible? Yes ☐ No ☐
   If yes, COBRA Administrator Name:
   _____
4. Offering a qualified high-deductible plan?
   Yes ☐ No ☐
   If yes, HealthEquity HSA through Presbyterian?
   Yes ☐ No ☐
   If yes, complete the HealthEquity enrollment forms.
5. Does employer wish to waive the waiting period for initial enrollment? Yes ☐ No ☐

Premium Contributions

Employee: _____% or $_____ Spouse: _____% or $_____ Dependents: _____% or $_____

Step 3 – Group Census

☐ Group attests they have 50 or less full-time equivalent employees based on IRS guidelines. Use the full-time equivalent employee (FTE) calculator online at **www.healthcare.gov/shop-calculators-fte** to verify your FTE count.

Total employees:	
Number of part-time or seasonal employees:	
Number of employees in the waiting period:	
Number of eligible employees (including waivers):	
Number of employees with other coverage waiving coverage:	
Number of employees without other coverage waiving coverage:	
Total number of employees enrolling:	
Total number of employees living and/or working outside of New Mexico:	

Step 4 – Medical Plan Selection

You may choose 1- 3 plans between HMO, PPO and Engage

☐ HMO Plans

Platinum Plan	Gold Plans	Silver Plans
☐ Platinum Elite $250 w/Gym	☐ Gold Elite $1,000 w/Gym ☐ Gold Elite $2,500 w/Gym ☐ Gold Premier $3,500 w/Gym	☐ Silver $3,500 Advantage HDHP/HSA w/Gym ☐ Silver Premier $4,000 w/Gym

☐ PPO Plans

Platinum Plan	Gold Plans	Silver Plans
☐ Platinum Elite $250 w/Gym	☐ Gold Elite $1,000 w/Gym ☐ Gold Elite $2,500 w/Gym ☐ Gold Premier $3,500 w/Gym	☐ Silver $3,500 Advantage HDHP/HSA w/Gym ☐ Silver Premier $4,000 w/Gym

☐ Engage Plans

Platinum Plan	Gold Plans	Silver Plans
☐ Platinum Engage $500 w/Gym with Limited Network	☐ Gold Engage $1,500 w/Gym Limited Network ☐ Gold Smart Choice EPO $3,500 w/Gym Limited Network	☐ Silver Smart Choice EPO $4,000 w/Gym limited Network ☐ Silver Engage $7,000 w/Gym limited Network ☐ Silver Engage $0 w/Gym limited Network

Step 5 – Dental and Vision Plan Selection

Available for groups with two or more enrolling.

BenefitSource Dental Plan Yes ☐ No ☐

If yes, please complete the **separate BenefitSource Employer Application** and select the High or Standard Option.

(Dental coverage is underwritten and administered by Companion Life Insurance Company)

Clear Vision by Presbyterian Yes ☐ No ☐

If yes, please complete the **separate Clear Vision by Presbyterian Application**

(Vision coverage is underwritten by Presbyterian Insurance Company, Inc. and Administered by Davis Vision)

Step 6 – Payment Information		
Select a payment option (automatic bank draft or bill me). Must include first month's premium payment with application.		
☐ Checking account ☐ Savings account ☐ Credit Card* ☐ Bill me (for groups with 10+ employees enrolled only) *Discover, Visa, MasterCard accepted.		
Name of bank:		Name of account holder:
Routing number:		Account number:
Name on card:		Credit card number:
Expiration date:	CVV:	Start date of payment:

Step 7 – Authorizations and Agreements

I hereby authorize and request Presbyterian to initiate and withdraw entries from the account indicated and the financial institution named for monthly premium payments required by the Group Subscriber Agreement/Summary Plan Description. This authorization is to remain in effect until Presbyterian and the financial institution named are notified in writing. I understand that I have the right to terminate this agreement by notifying my financial institution. However, I understand that prearranged withdrawal entries are the required method of premium payment under the Group Subscriber Agreement/Summary Plan Description.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FORM FOR PAYMENT OF A LOSS OF BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. PRESBYTERIAN HEALTH PLAN, INC. MAY TERMINATE A MEMBER FOR ANY TYPE OF FRAUDULENT ACTIVITY.

I acknowledge that I have read and understand this application in its entirety.

Signature of group contact

X_____ Date:_____

Signature of billing contact

X_____ Date:_____

Agent and Broker Information	
First and last name:	Phone number:
Agency name:	National Provider Number:

Employee Action Form

Scan and email this completed form to enrollmentdept@phs.org or fax to the Presbyterian Sales Department at (505) 923-8225.

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

EMPLOYER INFORMATION

Employer:	Sub-group/Department:	Group Number:

SECTION A: TYPE OF ACTION

☐ New Enrollment or Qualifying Event:	☐ Waive Coverage (complete Section A, sign and date)	☐ Terminate Coverage
☐ Open/New Enrollment ☐ Qualifying Event: ☐ New Hire ☐ Newborn ☐ Marriage ☐ Court Order ☐ Adoption/Placement of Adoption Date of Event:_____*attach documented proof of event.*	☐ Other Coverage ☐ Individual ☐ Medicare ☐ Medicaid ☐ Other Employer: _____ ☐ Selecting no coverage	Date: Reason: ☐ Termination ☐ Death ☐ Cancel Employee/Dependent
Benefit Plan Selected:	Coverage selected: ☐ Single ☐ Domestic Partner ☐ EE + Child(ren) ☐ Family	
Dental Coverage Selected: ☐ Yes ☐ No (if yes, all family members will be enrolled in the plan selected by employer)		

SECTION B: EMPLOYEE INFORMATION

Employee Last Name:	Employee First Name & MI:	Date of Birth:	Phone Numbers:		Social Security Number:
			Work:		
			Home/Cell:		
Mailing Address:		City:	State:	Zip:	Email Address:

Employment Status:	Date of Hire:	Gender:	Race (optional)	Ethnicity (optional):	Other Language/Disability Needs:
☐ Full Time ☐ Part Time # of hours:_____			☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Two or more races	☐ Hispanic/Latino ☐ Non-Hispanic/Latino	Primary Care:

SECTION C: DEPENDENT INFORMATION

Dependent Type:	Last Name:	First Name and MI:	Social Security #:	Gender:	Date of Birth:	Eff. Date:	Primary Care:	Court order?
Spouse								
Child								
Child								
Child								
Child								

SECTION D: OTHER MEDICAL BENEFITS FOR COORDINATION (if applicable)

Family Member Name(s):	☐ Private Insurance: _____	☐ Medicare #:_____	☐ Not applicable

SECTION E: CONSENT / SIGNATURES

By signing this application you agree you have read all pages and agree that all information is correct and you have authority to act on behalf of and fully bind all of the dependents with respect to every provision of the Group Subscriber Agreement.

Employee Signature:		Date Signed:	

Please Read Carefully

Payroll Deduction
I HEREBY AUTHORIZE my employer to deduct from my pay check any required contribution for group benefits for which I am eligible.

Release of Protected Health Information
I HEREBY CONSENT to the extent permitted by applicable law to the use by or the release of my Protected Health Information (PHI) by any person or entity including without limitation; practitioners, providers, and insurance companies to Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. (Presbyterian) or its designees for any permitted purpose, including but not limited to; quality assurance, utilization review, processing of claims, financial audits, or other purposes related to the treatment, payment, or healthcare operations activities of Presbyterian. This consent shall not permit use of PHI when an authorization is required by law. For full description of Presbyterian's privacy practices as related to oral, written and electronic data and communication, please visit our website at www.phs.org/Pages/privacy-security.aspx or call Customer Service at (505) 923-5678.

Group Subscriber Agreement/Summary Plan Description/Certificate of Insurance
I understand I can access my Presbyterian Group Subscriber Agreement, Summary Plan Description or Certificate of Insurance, which contains the covered benefits, utilization management services, limitations, and exclusions applicable to my healthcare plan at www.phs.org/formsanddocuments. I understand that a Presbyterian representative or my personnel office will further explain the coverage for which I am eligible upon my request. I understand that my healthcare coverage is subject to the eligibility dates specified by my employer and Presbyterian. I will be financially responsible for any treatment received outside of the dates. I understand that I shall abide bythe provisions of the coverage in the Group Subscriber Agreement or Summary Plan Description or Certificate of Insurance under which I am enrolled. I understand that it is my responsibility to report to my employer any changes in the eligibility of my dependents within 31 days or as specified in the Group Letter of Agreement. Exclusions, limitations, rights and responsibilities can be reviewed in Group Subscriber Agreement. Please call 1-866-869-7737 to request a copy of this agreement.

Waiver of Health Coverage
I understand that by declining Presbyterian coverage for myself (and my family, if applicable) through my employer that:

1. I may not elect or enroll in this coverage until the next open enrollment period unless I experience an involuntary loss of coverage or acquire a new dependent.
2. I may in the future under certain circumstances be able to enroll myself (and my family, if applicable) in the plan provided that I request enrollment within 31 days after the other coverage ends.
3. In addition, if I acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Enrollment Instructions
Please complete all of the applicable sections of the Employee Action Form (enrollment form). Sign and date the form and return it to your employer's benefits administrator. The benefits administrator will write in your effective date. The effective date is the date your coverage under Presbyterian begins.
Any services provided prior to this date will not be covered by Presbyterian. Scan and email this completed form to enrollmentdept@phs.org or fax to the Presbyterian Sales Department at (505) 923-8225.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

GROUP DENTAL POLICY APPLICATION



Underwritten by: Companion Life Insurance Company

P.O. Box 100102

Columbia, South Carolina 29202

(803) 735-1251

Administered by: Companion Life Insurance Company

800 Main Street

P.O. Box 1535

Dubuque, IA 52004-1535

Telephone Number: (877) 676-5789

Fax: (563) 577-3351

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Employer.

Please Print or Type PHP Group # _____

POLICYHOLDER INFORMATION

1. Full Legal Name of Employer (As it should appear in Policy) Telephone Number

2. Employer's Federal Tax ID Number Full Years in Business

3. Street Address City State ZIP

P.O. Box City State ZIP

4. Administrative Correspondence with the Employer should be addressed to:
Name Title Email Address

5. Nature of Business

6. Requested Effective Date:

7. Are there subsidiary or affiliate businesses covered under this plan? ☐ Yes ☐ No
If YES, please state name and nature of each subsidiary or affiliate.

Are separate billings required? ☐ Yes ☐ No
If YES, please provide billing instructions.

8. Type of Administration: ☐ Home-Office Administered ☐ Self-Administered ☐ Third Party Administered

TPA Name _____

ELIGIBILITY INFORMATION

9. An Eligible Active Employee is Full Time and works _____ hours or more per week and is a legal resident or citizen of the U.S.

BILLING INSTRUCTIONS

10. Frequency: ☐ Monthly
Billing Method: ☐ Electronic - Date of 1st Deduction _____
Amount submitted with Application $

11. Billing Agent's Name

12. Billing Address – Street Address, City, State, Zip Code (If different from the address above)

13. Employer's authorized Representative Printed Name

14. Employer's authorized Representative Signature Date

COVERAGE INFORMATION
SEE ATTACHED PROPOSAL FOR SPECIFICATIONS FOR INSURANCE

15. Will the requested insurance replace existing insurance? ☐ Yes ☐ No
If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date:

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

If YES, check coverages being replaced: ☐ Preventive ☐ Basic ☐ Major ☐ Orthodontia

16. Current eligible enrollees are to be covered:
☐ Immediately on the requested effective date.
☐ After _____ days of continuous employment
☐ 1st of the month following _____ days of continuous employment

17. Employees after the plan effective dates are to be covered:
☐ Immediately on the date of hire.
☐ After _____ days of continuous employment.
☐ 1st of the month following _____ days of continuous employment

18. Are any Employees excluded from coverage? ☐ Yes ☐ No
If YES, please describe

19. Number of eligible Employees:
Number of enrolled Employees:

20. Percent of Premium Paid by Employer Enrollee Only _____ % Dependents _____ %
Total Employer Defined Contribution: Enrollee Only $ _____ Dependents $ _____
Additional notes:

21. Is prior insurance credit (takeover benefits) requested? ☐ Yes ☐ No

22. The following documentation is required when prior insurance credit is requested. Your prior dental plan must have been in effect continuously for at least 12 months prior to effective date.
- Evidence that the prior carrier's coverage has been in force for at least 12 months.
- A copy of the most recent bill which includes a listing of all covered enrollees.
- A copy of the prior dental plan.

23. SPECIAL REQUESTS/INSTRUCTIONS

SMALL GROUP Plan Options: (_____Standard no Ortho) (_____Standard Child w Ortho) (_____Standard Child & Adult) OR (_____High no Ortho) (_____High Child Ortho) (_____High Adult & Child Ortho)
_

LARGE GROUP Plan & Tier Options: { _____Dental Essentials _____2 Tier_____ 3 Tier _____ 4 Tier } { _____ Dental Choice _____2 Tier _____ 3 Tier_____ 4 Tier }
{ _____ Dental Choice Plus: _____ 2 Tier _____ 3 Tier, _____ 4 Tier_____ }

EMPLOYER'S SIGNATURE

DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED IN WRITING BY THE INSURANCE COMPANY OF ACCEPTANCE OF THIS APPLICATION

The undersigned, who is an officer of Employer and authorized to enter into this contract, certifies the following to be true:
1) all answers contained herein are true and complete;
2) the Company may institute inspection reports with regard to questions answered herein;
3) the Company may decline acceptance of the Application or where permitted by law, any person for whom coverage is requested;
4) no coverage will become effective under this plan of insurance until written approval is received from the Company; and
5) that the Company may terminate the policy(ies) by giving advance written notice as required in the Policy.

FRAUD NOTICE

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PLEASE READ CAREFULLY

The Policy forms will be delivered to the group electronically unless you request in writing to receive a paper copy. The Certificate package for distribution to all insureds will be delivered to you electronically unless you request in writing to receive a paper copy for distribution.

Quotations were based on the proposal data submitted to Companion Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.
If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Companion Life's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. Otherwise, insurance becomes effective only when a policy is delivered and accepted in writing. In the interim, liability is limited to a return of the original deposit, if any Only Companion Life's home office has the authority to guarantee the acceptability of the requested insurance.

Dated at _____ this_____ day of_____, 20_____
City/State

_____ _____
Signature of Employer Title

AGENT/BROKER'S REPORT

24. INITIAL DEPOSIT $_____

25. Have you explained to the Employer that an Employee not actively at work on the policy effective date will not be covered until such Employee returns to active work full time unless approved in writing by an underwriter or officer of Companion Life?
☐ Yes ☐ No

Remarks

26. Is there another group insurance plan(s) which duplicates any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)? ☐ Yes ☐ No

If YES, please describe the benefit amounts and purpose(s) of this plan(s).

27. Is Agent or Broker licensed in the state of this group for the types of insurance solicited? ☐ Yes ☐ No

28. To the best of the Agent's or Broker's knowledge, replacement
☐ is involved with this transaction.
☐ is not involved with this transaction.

29. Agent/Broker Name (Please Print)_____

Agent/Broker Telephone Number_____

Agent/Broker Email Address _____

30 Signature of Agent/Broker _____Date _____

Companion Life

www.CompanionLife.com

PRODUCTS NOT APPROVED IN ALL STATES

GROUP DENTAL EMPLOYEE ENROLLMENT FORM

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

Administered by:
Companion Life Insurance Company
800 Main Street, P.O. Box 1535
Dubuque, IA 52004-1535
Telephone Number: 877-676-5789
Fax: 563-557-3351

Underwritten by: Companion Life Insurance Company

Companion Life

P.O. Box 100102 | Columbia, SC 29202-3102
800-753-0404 (Phone) | 800-836-5433 (Fax)

Companion Life Insurance Company			Companion Life Use ONLY
□ New Employee	□ Change Address	□ COBRA	Approved: □ Declined: □
□ Add/Increase Coverage	□ Change Dependent Coverage		Date: _____
	□ Change Class or Status		By: _____
	□ Terminate Coverage		

POLICYHOLDER INFORMATION – to be completed by the Policyholder or Group Administrator

Employer Name:_____ DBA:_____

Group Number:_____ Dept/Div Number:_____ Class:_____

ENROLLEE INFORMATION (PLEASE PRINT)–to be completed by the Employee/Enrollee

Last Name (Include Jr., Sr., etc.)		First Name		M.I.
Street Address		Apt Number / City		State/Zip
Social Security Number		Primary Phone Number Work Phone Number		Email Address
Male ☐ Female ☐	Date of Birth(MM-DD-YY) / /	☐ Weekly ☐ Monthly ☐ Annually Earnings$_____ Do not include overtime or bonuses		
Marital Status ☐ Single ☐ Married	Occupation	Hours Worked Per Week _____	Hire Date: / / Coverage Effective Date: / /	

PLAN AND COVERAGE SELECTION

☐ Employee ☐ Employee + Spouse ☐ Employee + Children ☐ Family

DEPENDENT INFORMATION (please attach additional pages as needed)			Do any of your Dependents have any other dental coverage?
Spouse Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
DEPENDENTS: Eligible Dependents are determined by your Employer's eligibility terms.			

If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Enrollee.

AUTHORIZATION FOR DEDUCTION

I ☐ agree ☐ do not agree to have the certificate documents delivered to the Policyholder electronically.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages. I affirm, to the best of my knowledge and belief, that all information given by me on this form is true and complete. I have read or had read to me any Fraud notice below applicable to my state of issue of this enrollment form.

Enrollee's Signature:_____ **Date:**_____

REFUSAL/WAIVER – Complete ONLY if you are declining coverage.

I have been offered insurance coverage as permitted by my Employer and decline to participate in the dental coverage. I understand that in the event I desire dental coverage at a later date, I may be required to furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, and the Company shall have the right to refuse any request.

Enrollee' Signature:_____ **Date:**_____

Please See Page 2 Companion Life Insurance Company Fraud Notices

FRAUD NOTICE

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PRESBYTERIAN

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

2027-2028
Presbyterian Health Plan Dental
Small Employer Groups

Plans are underwritten by Companion Life Insurance Company and administered by BenefitSource, Inc.

Please check one:

Standard Option		High Option	
☐ 4-tier		☐ 4-tier	
Employee	$26.18	Employee	$32.73
Employee plus Spouse	$56.44	Employee plus Spouse	$73.05
Employee plus Child(ren)	$54.59	Employee plus Child(ren)	$67.22
Employee plus Family	$82.90	Employee plus Family	$99.88
Standard Child Ortho		**High Child Ortho**	
☐ 4-tier		☐ 4-tier	
Employee	$26.18	Employee	$32.73
Employee plus Spouse	$56.44	Employee plus Spouse	$73.05
Employee plus Child(ren)	$61.14	Employee plus Child(ren)	$75.29
Employee plus Family	$92.85	Employee plus Family	$111.87
Standard Adult/Child Ortho		**High Adult/Child Ortho**	
☐ 4-tier		☐ 4-tier	
Employee	$27.82	Employee	$35.02
Employee plus Spouse	$59.87	Employee plus Spouse	$78.16
Employee plus Child(ren)	$64.69	Employee plus Child(ren)	$80.56
Employee plus Family	$98.21	Employee plus Family	$119.70

Please select a dental plan option and submit this completed form with your medical plan new business or renewal paperwork. All employees and their dependents enrolled in an employer's medical plan with Presbyterian Health Plan will have the option to enroll in the plan selected. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Group Name: _____

Group Number:_____ Effective Date:_____

Signature:_____Date:_____

PRESBYTERIAN
Insurance Company, Inc.

Clear Vision by Presbyterian

Fully Insured Small Group Employer Group
Application and Agreement

Complete and Return This Form	
By Fax: (505) 923-8225	By Mail: Clear Vision by Presbyterian P.O. Box 26268, Albuquerque, NM 87125

Clear Vision Plan Selection (select one)	
Core	**Classic**
☐ $0.97 PMPM with 100% Employer Contribution	☐ $3.31 PMPM with 100% Employer Contribution
☐ $1.13 PMPM with 50% Employer Contribution	☐ $3.93 PMPM with 50% Employer Contribution
☐ $1.21 PMPM with 25% Employer Contribution	☐ $4.24 PMPM with 25% Employer Contribution
☐ $1.28 PMPM with No Employer Contribution	☐ $4.55 PMPM with No Employer Contribution
Complete	**Signature**
☐ $5.22 PMPM with 100% Employer Contribution	☐ $7.04 PMPM with 100% Employer Contribution
☐ $6.22 PMPM with 50% Employer Contribution	☐ $8.40 PMPM with 50% Employer Contribution
☐ $6.72 PMPM with 25% Employer Contribution	☐ $9.07 PMPM with 25% Employer Contribution
☐ $7.22 PMPM with No Employer Contribution	☐ $9.76 PMPM with No Employer Contribution

Employer Group Information			
Requested Effective Date (mm/dd/yyyy)			
Group Name		Tax ID Number	
Group Legal Name (if different than above)			
Is this company affiliated with any other companies? ☐ Yes ☐ No If yes, affiliation's name:			
Employer Group Contact Information			
Group Contact Name	Group Contact Title	Billing Contact Name	Billing Contact Title
Group Contact Phone		Billing Contact Name	
Group Contact Email		Billing Contact Email	
Group Physical Address (no P.O. Boxes)			
City, State, Zip		County	
Group Billing Address (if different from physical address)			
City, State, Zip		County	

Eligibility

Waiting Period

- ☐ Date of hire
- ☐ First of the month following the date of hire
- ☐ First of the month following 30 days of employment
- ☐ First of the month following 60 days of employment
- ☐ Effective on the 91st date of employment

Eligibility

1. Does the employer wish to waive the waiting period for initial enrollment?
   Yes ☐ No ☐
2. Does part-time employment apply to the waiting period?
   Yes ☐ No ☐
3. Does the group agree to domestic partner coverage?
   Yes ☐ No ☐
4. Is the group COBRA eligible?
   Yes ☐ No ☐
5. If Yes, COBRA Administrator Name:
   _____

Group Census

Group attests they have 50 or less full-time equivalent employees based on IRS guidelines.
Use the full-time equivalent employee (FTE) calculator online at **www.healthcare.gov/shop-calculators-fte** to verify your FTE count.

Total Employees _____

Number of part-time employees or seasonal employees _____

Number of employees in the waiting period _____

Number of eligible employees (including waivers) _____

Number of employees with other coverage waving coverage _____

Number of employees without other coverage waving coverage _____

Total number of employees enrolling _____

Total number of employees living and or working outside of New Mexico _____

Payment Information

Select a payment option. Must include the first month's premium payment with the application.
Discover, Visa and Mastercard are accepted.

☐ Checking account ☐ Savings account

Name of Bank _____ Name of Account Holder_____

Routing Number _____ Account Number _____

☐ Credit Card

Name on Card _____ Credit Card Number _____

Exp. Date _____ CVV _____

Authorizations and Agreements

By signing this Agreement, the Group acknowledges that it has read and understands the terms and conditions of the Agreement with Presbyterian Insurance Company, Inc. and represents that the information it has provided to Presbyterian is complete and accurate.

I hereby authorize and request Presbyterian to initiate and withdraw entries from the account indicated and the financial institution named for monthly premium payments required by the Vision Policy and Summary of Benefits. This authorization is to remain in effect until Presbyterian and the financial institution named are notified in writing. I understand that I have the right to terminate this agreement by notifying my financial institution. However, I understand that prearranged withdrawal entries are the required method of premium payment under the vision policy and summary of benefits.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FORM FOR PAYMENT OF A LOSS OF BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. PRESBYTERIAN INSURANCE COMPANY, INC. MAY TERMINATE A MEMBER FOR ANY TYPE OF FRAUDULENT ACTIVITY.

I acknowledge that I have read and understand this application in its entirety.

Signature of group contact

X_____ Date:_____

Signature of billing contact

X_____ Date:_____

Agent Information

First and Last Name	Phone Number
Agency Name	National Producer Number

PRESBYTERIAN
Insurance Company, Inc.

Clear Vision by Presbyterian
Group Member Enrollment Form

For questions, please contact your employer or your Presbyterian Account Manager.

Complete and return this form to	
By Fax: (505) 923-8225	By Mail: Clear Vision by Presbyterian P.O. Box 26268, Albuquerque, NM 87125

Clear Vision Plan Selection (select one)			
☐ **Core**	☐ **Classic**	☐ **Complete**	☐ **Signature**

Group Information	
Group Name:	Group Account Number:

Applicant Information			
First Name, Middle Initial, Last Name, Suffix:			
Social Security Number:			
Physical Address (no P.O. boxes):			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:

Contact Information		
Phone:	Cell Phone:	Email:
Ethnicity: (Optional)	Race: (Optional)	

Dependent Information				
Dependent Name First, Middle Initial, Last	**Relationship** Spouse/Child	**Gender**	**Date of Birth** mm/dd/yyyy	**SSN** Required
If you have other dependents to include, make a copy of this page and attach.				

Terms and Conditions
I understand applicants enrolled for coverage shall be provided a 10-day period from the effective date of coverage to examine and return the contract and have the premium refunded. If services were received during the 10-day period, and the member returns the contract to receive a refund of the premium paid, they must pay for such services. I understand covered benefits, services, utilization management procedures, exclusions, and limitations are subject to the provisions of the Policy. These documents may be found at **www.phs.org/formsanddocuments** or you may contact our Presbyterian Customer Service Center at **(505) 923-7528** or **1-855-923-7528** (TTY:711), Monday through Friday from 7 a.m. to 6 p.m. For consumer complaints you may contact the New Mexico Office of Superintendent of Insurance at **https://www.osi.state.nm.us** or **1-855-427-5674** for assistance. I hereby authorize to the extent permitted by applicable law, the use or release of my protected health information (PHI) by any person or entity, without limitation including practitioners, providers, and insurance companies to PIC or its designees for any permitted purpose. Purposes include, but are not limited to, evaluating my application for insurance, quality assurance, utilization review, processing of claims, financial audits, or other purposes related to the treatment, payment, or healthcare operations activities of PIC. This consent shall not permit the use or disclosure of PHI when authorization is required by law. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. Notices of Privacy Practices can be found online at **www.phs.org/privacy-security**. This authorization shall be valid for two years from this date and you have the right to revoke this authorization at any time by sending written notice to Presbyterian. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FORM FOR PAYMENT OF A LOSS OF BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. PRESBYTERIAN INSURANCE COMPANY, INC. MAY TERMINATE A MEMBER FOR ANY TYPE OF FRAUDULENT ACTIVITY. I understand that I am entitled to a copy of this signed form upon request. I acknowledge that I have read and understand this form in its entirety. The application will expire 60 days from the date of signature.

Signature:	Date:

Is your group COBRA eligible?

If your group has 20 or more full-time employees and would like to use HealthEquity® as your COBRA administrator, complete the questionnaire below.

HealthEquity® COBRA Questionnaire

Please return completed form to CarrierSalesSubmission@healthequity.com to begin HealthEquity's COBRA implementation. An Implementation Manager (IM) will schedule a kickoff call with you to review the COBRA process and gather additional information and documents required for your account setup.

_____
Company Name *(as it should appear on the account)*

_____
Address

_____
City/State/Zip

_____
FEIN (should be 9 digits)

Who should be invited to schedule your required Implementation Kick-Off call?*

Name:	Title:
Email:	Phone:

**The contact listed above will receive a Welcome Email, which will include a link taking them to their Implementation Manager's calendar, so they can confirm a date and time that best suits their scheduling needs. Once the call has been scheduled, the contact above is welcome to forward the invite to any additional people that should also join the call.*

Additional Notes:

_____

_____

If you need help with this questionnaire or have general questions regarding the COBRA services being offered, please reach out to CarrierSalesSubmission@HealthEquity.com so a member of our team can assist.

SIGNATURE BY THE GROUP

By signing this Agreement, the Group acknowledges that it has read and understands the terms and conditions of the Agreement with Presbyterian Health Plan, Inc. and/or Presbyterian Insurance Company, Inc. and represents that the information it has provided to Presbyterian is complete and accurate.

_____
Effective Date

_____
Group Number

_____
Group Name (the "Group")

_____
Title

_____
Signature Date

_____
Group Signature

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

by: Heather Thiltgen

H Thiltgen

Title: **President**
P.O. Box 27489
Albuquerque, New Mexico 87125-7489

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

GROUP LETTER OF AGREEMENT

SMALL GROUP 2 - 50 ELIGIBLE FULL TIME EMPLOYEES

(HMO products administered by Presbyterian Health Plan, Inc.;
PPO products administered by Presbyterian Insurance Company, Inc.)

This Agreement ("Agreement") is by and between Presbyterian Health Plan, Inc. ("PHP"), a New Mexico corporation, and/or Presbyterian Insurance Company, Inc. ("PIC"), a New Mexico corporation, and the Group. PHP and PIC are referred to herein as "Presbyterian".

WHEREAS, Presbyterian is a New Mexico corporation authorized to do business as a Health Plan and/or Insurance Company in Presbyterian's licensed service area in the state of New Mexico; and

WHEREAS, the Group is a viable business entity licensed to do business in the State of New Mexico and operating within the scope of its license and charter; and

WHEREAS, the Group has a minimum of two and no more than 50, eligible, active employees who reside or work in the service area; and

WHEREAS, the Group has requested and received approval for coverage for enrollment of Out-of-Area employees when applicable; and

WHEREAS, the Group has offered Presbyterian as the only health plan option to its employees, unless the Group has requested and received approval from Presbyterian to offer more than one plan; and

WHEREAS, the issuance of this Agreement shall be deemed to constitute proper notice of the renewable provisions, as set forth and subject to the requirements in this Agreement. If a change in benefit plan is desired, a request must be submitted to Presbyterian no later than 10 days before the Effective Date of the benefit change.

NOW, THEREFORE, the parties agree as follows:

Services: Presbyterian agrees to provide, through enrollment in Presbyterian, the services described in the current Presbyterian Group Subscriber Agreement, and any riders or amendments thereto ("Group Subscriber Agreement"), a copy of which has been, or will be upon request, provided to the Group and the terms of which are hereby incorporated by reference, Presbyterian will enroll those Group employees and their Dependents who are eligible as outlined in the Group's company policy and approved by Presbyterian under the terms of Paragraph 5 of this Agreement, to enroll in Presbyterian as of the effective date of such enrollment. Dependents include, spouse, children, and if applicable, qualified domestic partners of eligible employees ("Dependents"). Presbyterian's obligation to provide services hereunder is subject to all terms, conditions, exclusions and limitations set forth in this Agreement and in the Presbyterian Group Subscriber Agreement and any riders or amendments thereto. If there is a conflict between this Agreement and the Presbyterian Group Subscriber Agreement and any riders or amendments thereto, this Agreement takes precedence.

1. **Payment:**

   a) In consideration of the enrollment in Presbyterian of eligible Group employees and Dependents, the Group agrees to pay to Presbyterian the monthly prepayment for each Group employee enrolled in Presbyterian,

based on the coverage selected by such employee as outlined in the attached rate sheet (s) ("Rates").

Agreed upon rates are guaranteed no less than 12 months from the period as outlined in the Rate Confirmation Sheet commencing with the Effective Date of this Agreement or signed Renewal Confirmation hereafter.

b) The Group understands that Presbyterian is a prepaid health plan. Payment of the total amount of monthly pre- payments due hereunder shall be made by the Group in advance of each month that Group employees are enrolled with Presbyterian. Presbyterian shall invoice the Group monthly for the subsequent month's coverage. Payment, as reflected in the invoice from Presbyterian, must be received by Presbyterian on or before the 1st day of the month of coverage as follows:

1) If the Group has two to nine employees enrolled, payment in the amount of Presbyterian's invoice will be withdrawn from the Group's bank account per the *Authorization Agreement for Prearranged Payments,* attached as Exhibit B. The transaction will occur on the 5th day of the month of coverage or the 1st banking day thereafter. Retroactive adjustments required by the termination or addition of enrollees shall be reflected in the subsequent month's invoice.

2) If the Group has 10-50 enrolled employees, the Group shall pay to Presbyterian each month the amount shown due on Presbyterian's monthly invoice. Premiums must be made payable to Presbyterian Health Plan, Inc. and/or Presbyterian Insurance Company, Inc. and remitted to:

Presbyterian Health Plan, Inc.
P.O. Box 911594
Denver, Colorado 80291-1594

Presbyterian Insurance Company, Inc.
P.O. Box 911600
Denver, CO 80291-1600

Group agrees to pay as billed. Retroactive adjustments required by the termination or addition of enrollees shall be reflected in the subsequent monthly invoices.

If the Group's enrollment changes from 10-50 enrolled employees to two to nine enrolled employees, the Group will be set-up for *Prearranged Payments* upon the group's next renewal.

c) Acceptance of late, partial or non-electronic payments by Presbyterian shall not constitute a waiver of any present or future rights Presbyterian would otherwise have under this Agreement.

d) If the transaction is returned by the Group's financial institution for insufficient funds, account closed, authorization revoked or any other reason caused by an act of the Group, Presbyterian will notify Group as soon as notification is received by Presbyterian. Payment of the amount billed plus a charge of $30.00 must be received by Presbyterian within 15 days after notification of non-payment is provided.

2. Amendments and Changes in Rates and Benefits:

a) In consideration of the enrollment in Presbyterian of eligible Group employees and Dependents, the Group agrees to pay to Presbyterian the monthly prepayment for each Group employee enrolled in Presbyterian, based on the coverage selected by such employee as outlined in the attached rate sheet (s) ("Rates").

Agreed upon rates are guaranteed no less than 12 months from the period as outlined in the Rate Confirmation Sheet commencing with the Effective Date of this Agreement or signed Renewal Confirmation hereafter.

b) The Group understands that Presbyterian is a prepaid health plan. Payment of the total amount of monthly pre- payments due hereunder shall be made by the Group in advance of each month that Group employees are enrolled with Presbyterian. Presbyterian shall invoice the Group monthly for the subsequent month's coverage. Payment, as reflected in the invoice from Presbyterian, must be received by Presbyterian on or before the 1st day of the month of coverage as follows:

1) If the Group has two to nine employees enrolled, payment in the amount of Presbyterian's invoice will be withdrawn from the Group's bank account per the *Authorization Agreement for Prearranged Payments,* attached as Exhibit B. The transaction will occur on the 5th day of the month of coverage or the 1st banking day thereafter. Retroactive adjustments required by the termination or addition of enrollees shall be reflected in the subsequent month's invoice.

2) If the Group has 10-50 enrolled employees, the Group shall pay to Presbyterian each month the amount shown due on Presbyterian's monthly invoice. Premiums must be made payable to Presbyterian Health Plan, Inc. and/or Presbyterian Insurance Company, Inc. and remitted to:

Presbyterian Health Plan, Inc. P.O. Box 911594 Denver, Colorado 80291-1594	Presbyterian Insurance Company, Inc. P.O. Box 911600 Denver, CO 80291-1600

Group agrees to pay as billed. Retroactive adjustments required by the termination or addition of enrollees shall be reflected in the subsequent monthly invoices.

If the Group's enrollment changes from 10-50 enrolled employees to two to nine enrolled employees, the Group will be set-up for *Prearranged Payments* upon the group's next renewal.

c) Acceptance of late, partial or non-electronic payments by Presbyterian shall not constitute a waiver of any present or future rights Presbyterian would otherwise have under this Agreement.

d) If the transaction is returned by the Group's financial institution for insufficient funds, account closed, authorization revoked or any other reason caused by an act of the Group, Presbyterian will notify Group as soon as notification is received by Presbyterian. Payment of the amount billed plus a charge of $30.00 must be received by Presbyterian within 15 days after notification of non-payment is provided.

3. Amendments and Changes in Rates and Benefits:

The parties at any time may agree in writing to amend or modify any provision of this Agreement or the nature and extent of the benefits provided hereunder provided all underwriting guidelines are adhered to. Presbyterian must give the Group a minimum of a sixty (60) days' notice of a rate increase. Notice must be in writing and postmarked, or delivered electronically or by hand no less than sixty (60) days prior to the effective date of the increase. A decrease in Rates may be made by Presbyterian at any time without notice.

a) Presbyterian shall not decrease in any manner the material benefits provided hereunder without notice to the Group and enrolled employees. The notice must be in writing and delivered by mail, hand delivered or electronically sent no less than sixty (60) days prior to the effective date of the benefit change.

b) The provision of notice to an enrolled Group employee as required in this Paragraph 3 shall be deemed to constitute proper notice hereunder to each of the employee's enrolled Dependents.

4. Enrollment:

a) Following prior inspection of appropriate Group marketing materials, the Group agrees to allow Presbyterian marketing representative's fair and reasonable access to Group members for enrollment purposes. The Group will permit Presbyterian periodic access to eligible Group members for continued enrollment purposes.

b) Any employee of the Group and any Dependent of an employee, who is eligible to enroll in Presbyterian as of the Effective Date of this Agreement, must apply for enrollment in Presbyterian within thirty-one (31) days from such Effective Date. Any such employee or Dependent who fails to enroll during this initial enrollment period shall not thereafter be allowed to enroll in Presbyterian under this Agreement except during subsequent annual Group enrollment periods identified by Presbyterian and the Group or as specified in Paragraph 4(g) of this Agreement. The employee must have satisfied the Group's established waiting period. Request for enrollment of the employee must be accompanied by an Employee Action Form.

c) Any employee and his/her Dependent(s) joining the Group initially becoming eligible for benefits between annual Group enrollment periods, shall be offered the opportunity to enroll in Presbyterian. Application for enrollment under this Subparagraph must be made within thirty-one (31) days after the date on which the employee meets or will meet Presbyterian and Group eligibility requirements. Employees or Dependents who fail to enroll prior to the expiration of this thirty-one (31) day period shall not thereafter be allowed to enroll in Presbyterian except during subsequent annual Group enrollment periods identified by Presbyterian and the Group or as specified in Subparagraph 4(g). Presbyterian coverage for persons enrolling under this Subparagraph shall become effective as outlined in the cover page of this Agreement.

d) Application for the enrollment of a new Dependent of an employee already enrolled in Presbyterian must be made within thirty-one (31) days of the date such Dependent first becomes eligible to enroll in Presbyterian under terms of this Agreement and the Presbyterian Group Subscriber Agreement. Any Dependent who is not enrolled during such thirty-one (31) day period shall not thereafter be allowed to enroll in Presbyterian except during subsequent annual Group enrollment periods identified by Presbyterian and the Group or as specified in Subparagraph 4(g).

e) An employee who failed to enroll in Presbyterian during a previous enrollment period but who would otherwise be eligible for coverage may enroll in Presbyterian within thirty-one (31) days of acquiring a new Dependent through marriage, birth, adoption or placement for adoption or Court Order, if the new Dependent is also enrolled within this time period. If the new Dependent is a child, the spouse or, if applicable, qualified domestic partner of the employee may also enroll during this time period. No other Dependents may enroll.

f) An eligible person may enroll as an employee or Dependent after the initial eligibility period if the person

loses coverage under all of the following circumstances:

1) 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

2) the employee stated in writing that employee was not enrolling because of such other coverage; and

3) the employee and/or Dependent is enrolled, and applicable prepayment made within thirty-one (31) days of the date coverage under COBRA was exhausted, or the date the coverage (or the employer's contribution toward coverage) was terminated; and

4) the person's coverage under the other plan or insurance:

   i. was under a COBRA continuation provision and the coverage under that provision was exhausted;

   ii. 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.

g) The Group shall notify Presbyterian of any enrolled employee or Dependent who, for any reason, ceases to be eligible for enrollment in Presbyterian under the terms of this Agreement and the Presbyterian Group Subscriber Agreement, and shall collect from the enrollee, the enrollee's Presbyterian ID card. The notification shall be made by the Group to Presbyterian in writing within thirty (30) days of the date such employee or Dependent loses eligibility. In the event the Group fails to notify Presbyterian within this thirty (30)-day period, and the employee or Dependent obtains benefits or services through Presbyterian after the requested date of termination of coverage, Presbyterian shall be entitled to recover from the Group premium payment at the prevailing Rates stated in this Agreement or subsequent renewal action(s), for all subsequent months through the end of the month in which the employee or Dependent last obtained benefits or services through Presbyterian.

5. Eligibility and Effective Date:

a) The Presbyterian Group Subscriber Agreement sets forth Presbyterian's eligibility requirements and effective dates of Presbyterian enrollment for Group employees, and their Dependents. Presbyterian shall not expel or refuse to enroll or re-enroll any person because of such person's health status, requirements for health care services, age, race, gender, or sexual orientation.

b) The Group's waiting period is outlined in the Group's original information paperwork or amended in writing during subsequent renewals or as approved by Presbyterian.

c) In order to address situations where employees reside and work outside of the service area, Presbyterian may offer side-by-side products to enroll employees anywhere in the United States once approved by Presbyterian.

6. Effective Date: This Agreement shall become effective as of the Effective Date specified in the signature page and shall continue for twelve months after the Effective Date.

This Agreement shall be guaranteed renewable, subject to the provisions of Paragraph 7 below. However, this Agreement may be modified based on the size of the Group upon renewal. Presbyterian shall notify the Group at least sixty (60) days prior to the renewal date of this Agreement of the Rates and terms and conditions of the renewal.

7. Termination:

a) The Group may terminate this Agreement at any time by giving Presbyterian thirty (30) days advance notice in writing. Such termination shall become effective only as of the last day of any month. If the Group does not specify such a day as the proposed date of termination, such termination shall nonetheless become effective only as of the later of (1) the last day of the month specified, or (2) the last day of the earliest month in which termination could be effected in compliance with the thirty (30)-day minimum notice requirement of this Subparagraph. In the event the Group fails to give Presbyterian at least thirty (30) days advance written notice of termination, the Group shall pay to Presbyterian, in addition to other damages to which Presbyterian may be entitled, all prepayment amounts that would be payable under this Agreement for the period extending until the last day of the earliest month in which termination would have been effective had the Group complied with the minimum advance notice requirements of this Subparagraph.

b) In the event that the Group has fewer than two employees eligible for Presbyterian coverage, or participation requirements specified in Subparagraph 4(b) are not met, or the Group may not be in compliance with the provisions of the plan or this Agreement, Presbyterian may terminate this Agreement by giving the Group thirty (30) days advance notice in writing. Any such termination shall become effective only as of the last day of any month, and the effective date of such termination shall be specified by Presbyterian in the written notice required by this Subparagraph. No such notice shall be required for non-payment. See Subparagraph (e) of this Paragraph.

c) In the event that the Group ceases to be a viable business entity operating within the scope of its license and charter for reasons including, but not limited to, closing the business, bankruptcy, or insolvency, Presbyterian may terminate this Agreement by giving the Group thirty (30) days advance notice in writing.

d) In the event Presbyterian terminates this Agreement as provided in Subparagraphs (b) or (c) or (f) of this Paragraph 7, the Group shall provide promptly, within five (5) days of receipt of Presbyterian's notice of termination, to each enrollee by hand delivery, by mail or by electronic notice to the enrollees. Termination of this Agreement by Presbyterian shall not become effective sooner than thirty (30) days after the date notice is sent to the employer.

e) In the event the Group fails to make the prepayment required under this Agreement (inclusive of any applicable late fees or charges) within fifteen days of the notification that the payment is due, Presbyterian will by written notice terminate this Agreement on the 30th day of notification of non-payment and termination will be effective as of the last date of payment. Non-payment shall be considered a voluntary termination by the Group.

f) In the event an individual enrollee has knowingly given false material information in connection with the enrollment of the Group, Presbyterian may terminate the Group retroactively effective as of the original Effective Date. Each Group employee shall be responsible for payment for all services rendered hereunder as of the effective date of such termination and shall reimburse Presbyterian for all such payments at

reasonable charges made by Presbyterian on behalf of the employee or any of employee's Dependent.

g) Presbyterian may terminate individual enrollees of Presbyterian as provided in the Presbyterian Group Subscriber Agreement.

8. Continuation:

a) Enrollees shall have the option to continue coverage with Presbyterian.

1) If applicable, enrollees may elect to continue Group coverage for a period of six months upon termination of employment with the Group or due to a reduction of hours by the Group which results in a loss of coverage for the enrollee; or

2) If applicable, enrollees may elect continuation of coverage under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, as amended;

3) Continuation of coverage shall be provided regardless of the enrollee's health status. **In the event this Agreement is terminated, coverage for enrollees who have opted for Continuation of Coverage under this Agreement shall also terminate.**

b) The Group shall be solely responsible for identifying persons entitled to continuation benefits, for providing all notices required to be provided in connection with the availability of such benefits, for billing and collecting any payments or premiums required by the Group in connection with such benefits, and for otherwise administering all facets of its continuation program. The parties agree that Presbyterian is not a Plan Administrator as that term is used in federal laws governing the provision of continuation benefits. Persons availing themselves of Group continuation benefits through enrollment in Presbyterian shall be considered and treated by Presbyterian as employees of the Group. Presbyterian shall assume no obligation with respect to such persons that is different from or in addition to its obligation to existing Group employees.

c) At the sole discretion of Presbyterian, Presbyterian may allow the Group to reinstate terminated enrollees within four (4) months of termination for those enrollees who have timely elected to receive continuation benefits. The Group shall remit all past due prepayment when billed by Presbyterian. Proof of timely election for continuation benefits will be required on reinstatements requested after the expiration of this four-month period. Presbyterian, upon request, will segregate all enrollees receiving continuation benefits into one billing category.

9. Conversion: If an enrollee ceases to be eligible for coverage through the Group and is no longer eligible for continuation benefits, the enrollee may apply for conversion coverage through a separate non-group membership agreement as provided in the Presbyterian Group Subscriber Agreement. The Group shall not incur any expense for or on behalf of an enrollee who has exercised enrollee's conversion rights. In the event that the Group's coverage is terminated, non-group membership will not be available.

10. Verification of Health Coverage (Certificates): Presbyterian agrees to provide verification of health coverage to all enrollees of the Group whose enrollment in Presbyterian terminates for any reason upon request of the terminated member. Presbyterian shall prepare and deliver the Certificates in compliance with all applicable requirements of state and federal law. The Group agrees to provide Presbyterian, upon request, with all

information necessary to complete the Certificates.

11. **Information Necessary for Administration of Agreement:** The Group shall provide Presbyterian with such information as Presbyterian may reasonably require for the administration of this Agreement. Presbyterian shall be entitled to rely upon information provided by the Group regarding the enrollment or termination of enrollment, eligibility, or loss of eligibility, of any Group employee, or Dependent. Presbyterian at its sole discretion may affect retroactive corrections of purely clerical errors made by the Group, but nothing herein shall require it to do so or constitute a waiver of Presbyterian's right to refuse to do so.

12. **Complete Agreement and Modification:** The complete terms and conditions of the Agreement between Presbyterian and the Group shall consist of this Agreement and exhibits, the Group Subscriber Agreement, the Rate Sheet and the Group's application. Except as provided in Paragraph 18 of this Agreement, no change, amendment or alterations hereto shall become effective unless in writing, signed by both parties.

13. **Assignment:** This Agreement shall not be assigned, delegated or transferred, in whole or in part, by the Group without the written consent of Presbyterian. Presbyterian may assign, delegate or transfer in whole or in part, this Agreement without the consent of Group.

14. **Applicable Law:** This Agreement and the rights and obligations hereunder shall be governed by and construed in accordance with the laws of the State of New Mexico.

15. **Internal Revenue Bulletin:** 2011-2 issued on January 10, 2011 under Notice 2011-1 Affordable Care Act Nondiscrimination Provisions Applicable to Insured Group Health Plans:

    Section 10101(d) of the Affordable Care Act adds § 2716 which references the substantive nondiscrimination requirements of § 105(h) of the Internal Revenue Code. Plan sponsors, who include employers, are solely responsible for complying with these rules. Employers or plan sponsors may not establish eligibility rules that favor highly compensated employees. An insured group health plan that fails to comply with these rules may be subject to: (1) an excise tax that generally applies for a plan failing to comply with the requirements (2) civil money penalties or (3) a civil action for employers. Employers or plan sponsors should consult their legal counsel to seek advice on the above requirements for non-discrimination as it relates to their choice of health care coverage.

16. **Notices:** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be mailed or hand-delivered to the persons at the addresses listed on the cover of this Agreement.

17. **Group Reinstatement:** A reinstatement may be requested by Group within 10 days of receiving their termination letter and will be considered provided there has not been more than one payment returned or one collection letter in the last twelve months. A request can be made to escalate the reinstatement request for management review.

18. **Dispute Resolution:** Representatives of the parties will meet, at the request of either party, in an attempt to resolve any controversy or claim (a "Dispute") relating to this Agreement. If the Dispute is not resolved within five days after the representatives meet to resolve the Dispute, the parties shall select a mediator (the "Mediator') to resolve the Dispute through non-binding mediation. Both parties agree to cooperate with the

Mediator in an effort to resolve the Dispute. If the Dispute is not resolved through either negotiation or mediation within 45 days after the Dispute is first identified, either party may exercise any rights available to the party to resolve the Dispute.

19. **Amendment:** This Agreement complies with the requirements of the Patient Protection and Affordable Care Act (''PPACA''), as amended, and the parties hereby agree that any requirements or other provisions expressly required by PPACA are hereby incorporated by reference. Upon the enactment of any law or regulation affecting PPACA, or the publication of any court decision relating to any such law, or the publication of any interpretive policy, opinion or guidance of any governmental agency charged with the enforcement of any such law or regulation, Presbyterian may, by written notice to the Group, amend this Agreement to comply with such law or regulation by providing 30 days written notice to the Group. Such amendment shall be binding upon Presbyterian and the Group at the end of the thirty-day period and shall not require the consent of the Group unless (a) the Group provides Presbyterian with notice of objection within the 30-day period; (b) the change has a material adverse economic effect upon the Group as reasonably determined by the Group; (c) such change is not made in order to comply with state or federal law; and (d)the Group delivers written notice to Presbyterian during such 30-day period terminating the Agreement pursuant to Subparagraph 7(a).

20. **Compliance:** The parties agree to comply with all applicable requirements of federal, state or local laws, rules and/or regulations, including any newly adopted and/or amended during the course of the Agreement.

21. **No Surprises Act:** Presbyterian agrees to provide the information necessary to satisfy the No Surprises Act requirement of health plans to disclose balance billing prohibitions and network and cost-sharing information to enrollees in accordance with Sec. 2715A of the Public Health Service Act, Sec. 720(c) of ERISA, and/or Sec. 9820(c) of the Internal Revenue Code, as applicable.

22. **Agreement and Renewal:** Issuance of this Agreement and the rates herein does not guarantee coverage or renewal of coverage and Presbyterian reserves the right to modify rates based upon changes in the demographics and Group size. Coverage shall begin as of the "Effective Date". This Agreement may be automatically renewed without the signing of another Agreement and renewal of coverage with substantially similar terms and conditions is guaranteed renewable provided (i) the Group informs Presbyterian of its intention to renew; and (ii) Presbyterian receives upon request, all information needed for Business Verification and Participation Verification, including but not limited to a SUTA (State Unemployment Taxes) or current Tax filing, a list of all employees on company letterhead if not part of the SUTA, and valid Waivers for any employees not enrolling ("Documents").

NOTES



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

P.O. Box 27489
Albuquerque, NM 87125-7489
www.phs.org

Sales Consultants: (505) 923-5807
Customer Service: (505) 923-5678
1-800-356-2219
TTY: 711