



Presbyterian Health Plan, Inc.

Group Subscriber Agreement and Guide to Your Managed Care Plan

Presbyterian Health Plan, Inc.

[Group Benefit Plans] HMO

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

Underwritten by Presbyterian Health Plan

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IMPORTANT PHONE NUMBERS AND ADDRESSES

Presbyterian Customer Service Center:

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

Phone:
(505) 923-5678 or toll-free
at 1-800-356-2219
TTY for the hearing
impaired: 711

Prior Authorization:

Address:
Presbyterian Health Plan
Attention: Health Services Department
P.O. Box 27489
Albuquerque, New Mexico 87125-7489

Phone:
(505) 923-5678 or toll-free
at 1-888-923-5757

Claims:

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

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

Appeals and Grievances:

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

Phone:
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at 1-800-356-2219

Website:

www.phs.org

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WELCOME TO PRESBYTERIAN HEALTH PLAN!

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

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

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

Our Agreement With You

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

Information you will find in this Agreement includes:

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

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

Please take time to read this Agreement and *Summary of Benefits and Coverage*, including Benefits, **Limitations**, and **Exclusions**. This Agreement describes your benefits and your

rights and responsibilities as our Member. It also gives details on how to choose or change your Primary Care Physician, what limits are placed on certain benefits, and what services are not Covered at all. Understanding how this Plan works can help you make the best use of your Covered Benefits.

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

Understanding This Agreement

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



Refer to

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



Exclusion

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



Prior Auth
Required

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



Timeframe
associated
with this item

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



Important
Information

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



Call PCSC
505-923--5678
or 1-800-356-
2219

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

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

Customer Assistance

Presbyterian Customer Service Center (PCSC)

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



Call PCSC
505-923-5678
1-800-356-
2219

Our Presbyterian Customer Service Center representatives are available Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711**. You may visit our website for useful health information and services at www.phs.org.

Consumer Assistance Coordinator

If you need assistance completing any of our forms, if you have special needs, or if you need assistance in protecting your rights as a Member, please call our Consumer Assistance Coordinator at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711** or visit our website at www.phs.org.

Written Correspondence

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

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

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

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

Member Rights

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

- Available and accessible services when medically necessary, 24 hours per day, 7 days per week for Urgent or Emergency Health Care Services, and for other Health Care Services as defined by the Agreement;
- Be treated with courtesy and consideration, and with respect for the Covered Person's dignity and need for privacy;
- Be provided with information concerning our policies and procedures regarding products, services, Providers, Appeals procedures and other information about Presbyterian Health Plan;
- To choose a Primary Care Practitioner within the limits of the Covered Benefits, plan network, and as provided by this rule, including the right to refuse care of specific Health Care Professionals;
- Receive from the Covered Person's Physician(s) or Provider, in terms that the Covered Person understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of our position on treatment options; if the Covered Person is not capable of understanding the information, the explanation shall be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the Covered Person's medical record;
- All the rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Covered Person understands;

- Prompt notification, as required in this rule, of termination or changes in benefits, services or Practitioner/Provider network;
- File a Complaint or Appeal with us or the Superintendent and to receive an answer to those Complaints in accordance with existing law;
- Privacy of medical and financial records maintained by us and our Health Care Providers, in accordance with existing law;
- Know upon request of any financial arrangements or provisions between Presbyterian Health Plan and our Practitioners/Providers which may restrict referral or treatment options or limit the services offered to Covered Persons;
- Adequate access to qualified Health Professionals for the treatment of Covered Benefits near where the Covered Person lives or works within our Service Area;
- To the extent available and applicable to us, to affordable health care, with limits on Out-of-pocket expenses, including the right to seek care from a non-participating (Out-of-network) Provider, and an explanation of a Covered Person's financial responsibility when services are provided by a non-participating (Out-of-network) Provider, or provided without required Prior Authorization;
- An approved example of the financial responsibility incurred by a Covered Person when going Out-of-network; inclusion of the entire “billing examples” provided by the Superintendent available on the Division's website at the time of the filing of the plan will be deemed satisfaction of this requirement; any substitution for, or changes to, the Division's “billing examples” requires written approval by the Superintendent, in our Health Care Benefit Plan that provides benefits for Out-of-network Coverage;
- Detailed information about Coverage, Maximum Benefits, and **Exclusions** of specific conditions, ailments or disorders, including restricted Prescription benefits, and all requirements that a Covered Person must follow for Prior Authorization and Utilization Review;
- A complete explanation of why care is denied, an opportunity to Appeal the decision to our internal review, the right to a secondary Appeal, and the right to request the Superintendent’s assistance.

Additional Member Rights and Responsibilities

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

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

- Have a clear, private and candid discussion about appropriate or Medically Necessary treatment options for your medical condition regardless of cost or benefit Coverage;
- Participate with your Practitioner/Provider in making decisions about your health care;
- Refuse care, treatment, medication or a specific Practitioner/Provider, after the consequences of your decision have been explained in a language that you understand;
- Seek a second opinion for surgery from another In-network Practitioner/Provider when you need additional information regarding recommended treatment or requested care;
- Receive Health Care Services in a non-discriminatory fashion. This means that you may not be denied Covered Services on the basis of race, color, sex, sexual preference, age, handicap, cultural or educational background, religion or national origin, economic or health status or source of payment for care. If you have a disability you have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act;
- Make recommendations regarding our Members' rights and responsibilities policies;
- Make your wishes known through an Advance Directive regarding health care decisions, such as living wills or right-to-die directives, consistent with federal and state laws and regulations;
- Choose a surrogate decision maker to assist with care decisions. If you are unable to understand your medical care, to have the health care explanation provided to the next of kin, guardian, agent or surrogate if available, and recorded in your medical record including, where appropriate, a medical release that you signed authorizing release of medical information;
- Receive a Certificate of Creditable Coverage when your enrollment under this Agreement terminates.

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

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



- Review your Group Subscriber Agreement (GSA) and if you have questions, contact our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call our **TTY line at 711**. You may visit our website at www.phs.org for clarification of Benefits, **Limitations**, and **Exclusions** outlined in this Subscriber Agreement;
- Notify us within 31 days of any change of name, address, telephone number, marital status, eligible Dependents or newborns;
- Immediately notify us of any loss or theft of your PHP Identification Card;
- Refuse to allow any other person to use your PHP Identification Card;
- Advise a Practitioner/Provider of your Coverage with us at the time of service. You may be required to pay for services if you do not inform your Practitioner/Provider of our Coverage;
- Pay all required, pre-determined Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time services are rendered when amounts due are made clear at that time;
- Pay for all services obtained prior to the effective date of this Agreement and subsequent to its termination or cancellation;
- Insure that all information you give to us in Applications for enrollment, questionnaires, forms or correspondence is true and complete;
- Be informed of the potential consequences of providing us with incorrect or incomplete information as described in this Agreement;
- Obtain Prior Authorization as described in the Prior Authorization Section;
- Pay any charges over Medicare allowable.

Consumer Advisory Board

We have established a Consumer Advisory Board and we want your participation. This Board meets quarterly and provides Members' perspectives, as health care consumers, on the products and services that we offer. In addition, we share information with the Consumer Advisory Board on how well the health plan is performing. The information we receive is very valuable and helps us improve the health of individuals, families and communities. If you are interested in serving on our Consumer Advisory Board, please call our Presbyterian Customer Service Center, Monday through Friday 7:00 am to 6:00 pm, at **(505) 923-5678 or 1-800-356-2219**. Hearing impaired users may call our **TTY line at 711**. You may also visit our website at www.phs.org.



HOW THE PLAN WORKS

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

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

Some preventive benefits are not subject to the Deductible. This means you can access this benefit and the plan will pay even if you have not met the individual or family Deductible. Please see the “Clinical Preventive Services” benefit on your *Summary of Benefits and Coverage* for further information. Prescription Drugs are not part of the Clinical Preventive Services benefit and thus, are subject to the Deductible and Coinsurance listed in the *Summary of Benefits and Coverage*.

We require that:



Refer to

➤ You must physically live or physically work (commuting daily) in the State of New Mexico (our Service Area) unless you are a Dependent and meet all of the terms and conditions for such Coverage as outlined in the **Eligibility, Enrollment and Effective Dates, Termination and Continuation of Coverage** Section.



Refer to

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



Refer to

➤ You select a Primary Care Physician (PCP) from the Provider Directory to coordinate all of your care.

➤ You pay your pre-determined Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time you receive Covered Services. We will reimburse the Practitioner/Provider the balance for Covered Services based upon Total Allowable Charges (some services may not require a Cost Sharing Deductible, Coinsurance and/or Copayment). Refer to your *Summary of Benefits and Coverage* to find Covered Services subject to Cost Sharing amounts.

➤ Under the Market Stabilization rule finalized on April 13, 2017, to the extent permitted by State law, Presbyterian Health Plan may attribute to any past-due premium amounts owed to it the initial premium payment made in accordance with the terms of the health insurance policy to effectuate coverage, for coverage in the 12-month period preceding the effective date. This is done in an effort to prohibit abuse of the grace period. **Be**

aware that failure to pay premiums in a preceding 12-month period may result in the group or individual's inability to effectuate new coverage until past-due premium payments and initial premium payments are satisfied.



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

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

Provider Directory



You will find our Primary Care Physicians close to where you live and work across the State. The Provider Directory is available on our website at www.phs.org or by calling our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711**.

The Provider Directory is subject to change and you should always verify the Practitioner/Provider's network status by visiting our website at <https://www.phs.org/Pages/find-a-doctor.aspx>.

Obtaining Health Care

How to Obtain Primary Care Services

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

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

You may want to ask relatives or friends if they have a PCP they would recommend. A Physician may not be a PCP for him/herself or immediate family members. If you do not designate a PCP on your enrollment form, PHP will select one for you. You may change

your PCP by contacting our Presbyterian Customer Service Center. The requested change will be effective the next business day after you call our Presbyterian Customer Service Center.

Women's Healthcare Provider/Practitioner

Any female Member age 13 or older may select an In-network Women's health care Practitioner/Provider listed as a PCP in our Provider Directory as her Primary Care Physician. In addition, a female Member age 13 or older who has not selected a Women's health care Practitioner/Provider as her Primary Care Physician may consult with an In-network Women's health care Provider/Practitioner, without a referral from her Primary Care Physician, for any gynecological service.

Specialist Care

As our Member, you must carefully follow all procedures and conditions for obtaining care from In-network specialists and/or Out-of-network Practitioners/Providers. Out-of-network Practitioners/Providers are covered for emergency care only. We no longer require a paper referral from your Primary Care Physician (PCP) for your visits to specialists. However, it is important to your health care that your PCP is included in the decisions about the specialists that you visit. Your PCP continues to be your partner for good health and is the best person to help you determine your needs for specialty care.

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

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



Refer to

Obtaining Care After Normal Physician Office Hours

Most Physicians offer an after-hours answering service. For non-emergency situations, you should phone your Primary Care Physician. The name and address of your PCP appears on your Identification Card. You will also find the phone number of your PCP in the Provider Directory.

If Emergency Health Care Services are needed, you should call 911, or seek treatment at an emergency room. If in need of Urgent Care, you may seek treatment at an Urgent Care Center that is available and open for business. Please note that some Urgent Care Centers are not open after 8:00 p.m. In such circumstances, it may be necessary to use an emergency room for care that is needed on an urgent basis. Please refer to the **Benefits Section, Accidental Injury / Urgent Care / Emergency Health Services / Observation /Trauma**



Refer to

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

In-Network Practitioners/Providers

In-network Practitioners/Providers, including Primary Care Physicians, specialists, facilities and ancillary Health Care Professionals, must be utilized, except in cases of an emergency. Members are responsible for paying the appropriate Cost Sharing (Deductible, Coinsurance and/or Copayments) directly to the In-network Practitioner/Provider at the time services are rendered when such amounts are clearly specified by the Practitioner/Provider.

Hospital Inpatient Admission and some other Health Care Services require our review and Prior Authorization before the services are provided. If you seek care from an In-network Practitioner/Provider, your In-network Practitioner/Provider will notify us and handle all aspects of your care. If that Practitioner/Provider fails to obtain a required Prior Authorization and the claim is denied, you will not be held accountable for those charges. Please refer to the **Prior Authorization Section** for complete details on Prior Authorization.



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



We do not require our In-network Practitioners/Providers to comply with any specified numbers, targeted averages, or maximum duration of patient visits.

Out-of-network Practitioners/Providers

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

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

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



If the services of an Out-of-network Practitioner/Provider are required, your In-network Practitioner/Provider must request and obtain Prior Authorization from our Medical Director

BEFORE services are performed, otherwise, we will not Cover the services and you will be responsible for payment.

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

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

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

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

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

Restrictions on Services Received Outside of the PHP Service Area



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

Sharing and benefits for an Emergency Health Care Service rendered by a non-participating Provider shall be the same as if rendered by a participating Provider.

National Health Care Practitioner/Provider Network

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



For additional information regarding National Health Care Practitioner/Providers please call our Presbyterian Customer Service Center prior to obtaining services Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711**.

Cost-sharing – Your Out-of-pocket Costs

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

Annual Calendar Year Deductible



Certain services, except Preventive Care Services as identified in the Summary of Benefits and Coverage, are subject to an Annual Calendar Year Deductible. The Annual Calendar Year Deductible is the amount you and your Covered Dependents must pay for Covered Health Care Services each Calendar Year before we begin to pay Covered Benefits for that Member. The Annual Calendar Year Deductible may not apply to all Health Care Services. Refer to your ***Summary of Benefits and Coverage*** for the amount of your Annual Calendar Year Deductible.

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

For double or family coverage, with two or more enrolled Members, the entire Family Deductible must be met before benefits will be paid for the family. However, if one (family) Member reaches the Individual Deductible amount before the Family has met the Family Deductible, the Plan will begin paying benefits for that Member who has met the Individual Deductible. The Family and Individual Deductible amounts are listed in the *Summary of Benefits and Coverage*.

Coinsurance

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



Annual Out-of-pocket Maximum



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

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

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

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



To inquire about the status of your specific Annual Out-of-pocket Maximum, you may call our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711**.

Office Visit Copayment



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

Utilization Management and Quality

We may review medical records, claims, and requests for Covered Services to establish that the services are/were Medically Necessary, delivered in the appropriate setting, consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of our professional medical consultants. Utilization management decisions are based only on appropriateness of care and service. We do not reward Practitioners or other Health Care Professionals conducting Utilization Review for denying coverage or services and we do not offer incentives to encourage underutilization.

Technology Assessment Committee

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

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

Transition of Care/Continuity

If you are in an ongoing course of treatment with an In-network Practitioner/Provider and that Provider/Practitioner becomes an Out-of-network Practitioner/Provider, you will be allowed to continue care from this Practitioner/Provider for a transitional period of time.

- If a Member's health care Practitioner/Provider leaves the PHP network, the Member may continue an ongoing course of treatment with that Practitioner/Provider for a transitional period of no less than 30 days.
- This "transitional period rule" does not apply for any Practitioner/Provider who has been terminated from the network for reasons related to medical competence, professional misbehavior, or circumstances involving fraud and abuse.

Please contact our Health Services Department at **1-888-923-5757** Monday through Friday from 8:00 a.m. to 5:00 p.m. for further information on Transition of Care/Continuity of Care.

Advance Directives

Advance Directives are the legal documents in which you give written instructions about your health care if in the future you cannot speak for yourself. You have the right to make choices about your own health care and the right to choose someone else to make health care decisions for you. Advance Directives help health care workers care for people.

Health Improvement Related Activities

We may offer incentives to Covered Persons to promote the delivery of preventive care or other health improvement activities. Health improvement activities may include participation in disease management programs, educational health programs or surveys regarding your understanding of your Covered Benefits. Your participation is strictly voluntary. The level and type of incentives will be determined based upon the nature of the preventive care or health improvement activity.

PRIOR AUTHORIZATION

This Section explains what Covered Health Care Services require Prior Authorization before you receive these services and how to obtain Prior Authorization. This is not an exhaustive list. Further information can be obtained through your PCP or at our website at www.phs.org.



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

What is Prior Authorization?

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

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

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

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

Prior Authorization Is Required

Certain services and supplies are Covered Benefits only if we Authorize them prior to the actual service or delivery of supplies. Authorization means our decision that a Health Care Service requested by your Practitioner/Provider or by you has been reviewed and, based upon information available, meets our requirements for Coverage and Medical Necessity, and the requested Health Care Service is therefore approved.

If a required Prior Authorization is not obtained for services by Out-of-Network Practitioners/Providers, except for Emergency Care, the Member will be responsible for the resulting charges. Services provided beyond the scope of the Prior Authorization are not Covered.

Prior Authorization when In-network

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

Prior Authorization when Out-of-network

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



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

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

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

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

Prior Authorization is required for Inpatient admissions, and all services related to the inpatient admission before you receive these services In-network or Out-of-network from any Practitioner/Provider, Health Care Facility or other Health Care Professional. Our network of Practitioners/Providers will obtain Prior Authorization for you when you receive care In-network. You are responsible for obtaining Prior Authorization before you receive care Out-of-network, except for Emergency Care.



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

Please Note: Due to the ever-changing nature of health care services, this is not an all-inclusive list. For access to the most current list, you may contact our Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711**. **You may also visit our website at www.phs.org.**

If you want to know more about Prior Authorization, please call our Presbyterian Customer Service Center, as soon as possible before services are provided.

- Acute Medical Detoxification
- All Hospital admissions, Inpatient non-emergent
- Bariatric Services and Surgery for the treatment of obesity
- Certified Hospice Care
- Clinical Trials (Investigational/Experimental)
- Computed Axial Tomography (CAT) scans in an outpatient setting
- Durable Medical Equipment
- Electroconvulsive Therapy (ECT)
- Foot Orthotics
- Genetic Testing
- Home Health Care Services/Home Health Intravenous Drugs
- Hyperbaric Oxygen
- Injectable Drugs, (includes Specialty Medications and Medical Drugs)

- Magnetic Resonance Imaging (MRI) in an outpatient setting
- Mental Health services - Inpatient, Partial Hospitalization and select outpatient services
- Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring System
- Newborn Delivery and Hospital Obstetrical services
- Nutritional Supplements
- Observation Services greater than 24 hours
- Organ transplants
- Orthotics
- Positron Emission Tomography (PET) scans in an outpatient setting
- Prescription Drugs/Medications
- Prosthetic Devices
- Reconstructive and potentially cosmetic procedures
- Selected Surgical/Diagnostic procedures
 - Ankle Subtalar Arthroereisis
 - Blepharoplasty/Brow Ptosis Surgery
 - Breast Reconstruction following Mastectomy
 - Breast reduction for gynecomastia
 - Cholecystectomy by Laparoscopy
 - Endoscopy Nasal/Sinus balloon dilation
 - Hysterectomy
 - Lumbar/Cervical Spine Surgery
 - Meniscus Implant and Allograft/Meniscus Transplant
 - Panniculectomy
 - Rhinoplasty
 - Tonsillectomy
 - Total Ankle Replacement
 - Total Hip Replacement

- Total Knee Replacement
- Skilled Nursing Facility care
- Special Inpatient services for example, private room and board and/or special duty nursing
- Special Medical Foods
- Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)
- Transplant Services
- Virtual Colonoscopy
- Wireless Capsule Endoscopy

Authorizing Inpatient Hospital Admission following an Emergency

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

Prior Authorization and Your Coverage



**Important
Information**

Obtaining **Prior Authorization does not guarantee your eligibility for coverage, or that benefits will be paid.**

- Eligibility and benefits are based on the date you received the services, not the date you received Prior Authorization.
- If you lose Coverage under this plan, services received after Coverage ends will not be Covered, even if we provided Prior Authorization.

Prior Authorization Decisions – Non-Emergency

We will evaluate non-emergent Prior Authorization requests and advise you and your Practitioner/Provider of our decision within five (5) working days.

Prior Authorization Decision – Expedited (Accelerated)

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

Prior Authorization Review – Initial Adverse Determination

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

We will also notify you and your Practitioner/Provider of the Adverse Determination by written or electronic communication sent within one (1) working day of a telephone notice. Our notice will include:

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



Please see the **Summary of Health Insurance Grievance Procedures Section** for information regarding how to request an internal review of any Adverse Determinations that we make.

BENEFITS

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

Specifically Covered



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

We determine whether a Health Care Service or supply is a specifically Covered Benefit. The fact that a Practitioner/Provider has prescribed, ordered, recommended, or approved a Health Care Service or supply does not guarantee that it is a Covered Benefit even if it is not listed as an **Exclusion**.

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

Medical Necessity

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

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

Experimental or Investigational drugs, medicines, treatments, procedures, or devices are not Covered.

Care Coordination and Case Management

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

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

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

Disease management lifestyle coaches work with you to help you better manage your chronic disease, such as diabetes, coronary artery disease or congestive heart failure. Care is focused on helping you identify goals and desires for improving management of your chronic disease.

PresRN

Presbyterian Health Plan members have access to PresRN, a nurse advice line available 24 hours a day, 7 days a week, including holidays. Pres RN is a no-cost service for Presbyterian Health Plan Members. Please call at (505) 923-5570 or 1-866-221-9679

Health Management Programs

Our clinically trained Health Care Professionals work with your Practitioners/Providers to help enhance your quality of life in three areas: Staying healthy, Living with illness, and Getting Better. We help you reach optimum health through Clinical Preventive Health Services (such as Screening Mammography and childhood immunizations) as well as with disease management for conditions such as asthma, depression, diabetes, smoking cessation, and high-risk pregnancies.



If you would like more information about these services, please call our Presbyterian Customer Services at **(505) 923-5678 or toll-free 1-800-356-2219** Monday through Friday from 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY number at 711**. Also, visit our website at www.phs.org.

Covered Benefits



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

Exclusion

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

- **Urgent Care**

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

- Members are encouraged to contact their Primary Care Physicians for an appointment, if available, before seeking care from another Practitioner/Provider.
- We must Prior-Authorize follow-up care by an Out-of-network Practitioner/Provider.
The Member will be responsible for charges that we do not Cover.

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

- **Emergency Health Care Services**

- This Agreement covers acute Emergency Health Care Services 24 hours per day, 7 days per week, when those services are needed immediately to prevent jeopardy to your health. You should seek medical treatment from an In-network Practitioner/Provider or facility whenever possible.
- If you cannot reasonably access an In-network Facility, we will arrange to Cover the care at an Out-of-Network facility without additional cost. Whether Out-of-network Emergency Health Care Service is appropriate will be determined by the Reasonable/Prudent Layperson standard discussed below.

In determining whether you acted as a Reasonable/Prudent Layperson we will consider the following factors:

- ◆ A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment
- ◆ The presenting symptoms

- ◆ Any circumstance that prevented you from using our established procedures for obtaining Emergency Health Care Services

- Coverage for trauma services and all other Emergency Health Care Services will continue at least until you are medically stable, do not require critical care, and can be safely transferred to an In-network facility based on the judgment of the attending Physician in consultant with us and in accordance with federal law.



Timeframe
associated
with this item

- We will provide reimbursement when you, acting in good faith, obtain Emergency Health Care Services for what reasonably appears to you, acting as a Reasonable/Prudent Layperson, to be an acute condition that requires immediate medical attention, even if your condition is later determined to not be an emergency.
- Prior Authorization is not required for Emergency Health Care Services. If you are admitted as an Inpatient to the Hospital, you or your Practitioner needs to notify us as soon as possible so we can review your Hospital stay.
- We will not deny a claim for Emergency Health services when the Member was referred to the emergency room by his or her PCP or by our representative.



Refer to

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



Prior Auth
Required

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

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

- **Observation Services**

Observation services are defined as Outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of

a bed and periodic monitoring by a Hospital's nursing staff which are reasonable and necessary to:

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



Prior Auth
Required

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



Refer to

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

➤ Ambulance Services

The following types of Ambulance Services are Covered: (1) Emergency Ambulance Services, (2) High-Risk Ambulance Services, and (3) Inter-facility Transfer services.

- **Emergency Ambulance Services** are defined as ground or air Ambulance Services delivered to a Member who requires Emergency Health Care Services under circumstances that would lead a Reasonable/Prudent Layperson acting in good faith to believe that transportation in any other vehicle would endanger your health. **Emergency Ambulance Services are Covered only under the following circumstances:**
 - Within New Mexico, to the nearest In-network facility where Emergency Health Care Services and treatment can be rendered, or to an Out-of-network facility if an In-network facility is not reasonably accessible. Such services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
 - Outside of New Mexico, to the nearest appropriate facility where Emergency Health Care Services and treatment can be rendered. Such services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.

- We will not pay more for air Ambulance Services than we would have paid for ground Ambulance Services over the same distance unless your condition renders the utilization of such ground transportation services medically inappropriate.
- In determining whether you acted in good faith as a Reasonable/Prudent Layperson when obtaining Emergency Ambulance Services, we will take the following factors into consideration:
 - ◆ Whether you required Emergency Health Care Services, as defined above
 - ◆ The presenting symptoms
 - ◆ Whether a Reasonable/Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health
 - ◆ Whether you were advised to seek an Ambulance Service by your Practitioner/Provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or **excluded** under this Agreement
 - ◆ Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols

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

- **High-Risk Ambulance Services** are defined as Ambulance Services that are:
 - Non-emergency
 - Medically Necessary for transporting a high-risk patient
 - Prescribed by your Practitioner/Provider

Coverage for High-Risk Ambulance Services is limited to:

- Air Ambulance Service when Medically Necessary. However, we will not pay more for air Ambulance Service than we would have paid for transportation over the same distance by ground Ambulance Services, unless your condition renders the utilization of such ground Ambulance Services medically inappropriate.

- Neonatal Ambulance Services, including ground or air Ambulance Service to the nearest Tertiary Care Facility when necessary to protect the life of a newborn.
- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.
- **Inter-facility Transfer Ambulance Services** are defined as ground or air Ambulance Service between Hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are Covered only if they are:
 - Medically Necessary
 - Prescribed by your Practitioner/Provider
 - Provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel

➤ **Bariatric Surgery**



Exclusion

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

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

- Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m² or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions; and



Prior Auth Required

Prior Authorization is required and services must be performed at an In-network facility that is designated by Presbyterian Health Plan, and designated as a bariatric surgery Center of Excellence by Centers for Medicare and Medicaid Services (CMS).

CLINICAL TRIALS

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

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

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

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

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

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

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

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



Certified Hospice Care

Exclusion

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



Prior Auth Required

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

- The Hospice benefit period is defined as follows:
 - Beginning on the date your Practitioner/Provider certifies that you are terminally ill with a life expectancy of six months or less.
 - Ending six months after it began, unless you require an extension of the Hospice benefit period below, or upon your death.
 - If you require an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and your Practitioner/Provider must **re-authorize** your medical condition to us. We will not Authorize more than one additional Hospice benefit period.
 - You must be a Covered Member throughout your Hospice benefit period.
- The following services are Covered:
 - Inpatient Hospice care
 - Practitioner/Provider visits by Certified Hospice Practitioner/Providers
 - Home Health Care Services by approved home health care personnel
 - Physical therapy
 - Medical supplies
 - Prescription Drugs and Medication for the pain and discomfort specifically related to the terminal illness
 - Medical transportation

- Respite care (care that provides a relief for the care-giver) for a period not to exceed five continuous days for every 60 days of Hospice care. No more than two respite care stays will be available during a Hospice benefit period.



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

➤ **Clinical Preventive Health Services**



Exclusion

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

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

We will provide Coverage for preventive benefits, as defined by the Affordable Care Act (ACA), without cost sharing regardless of sex assigned at birth, gender identity, or gender of the individual.

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

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

Screenings and Counseling Services

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

- Preventive Physical Examinations
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam

- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a Low-Density Lipoprotein (LDL) level and a High-Density Lipoprotein (HDL) level
- Periodic stool examination for the presence of blood for all persons 40 years of age or older
- Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:
 - Fecal occult blood testing (FOBT)
 - Flexible Sigmoidoscopy
 - Colonoscopy
 - Virtual Colonoscopy - Requires **Prior Authorization**
 - Double contrast barium enema



**Prior Auth
Required**



Refer to

- Smoking Cessation Program - Refer to **Smoking Cessation Counseling/Program in this Section.**
- Screening to determine the need for vision and hearing correction
- Periodic glaucoma eye test
- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV and sexually transmitted infections, as well as counseling for drug and Tobacco use, healthy eating and other common health concerns.
- Health education and consultation from In-network Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members 19 years of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive health care practices.

Routine Immunizations

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

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

Childhood Preventive Health Services

Childhood Preventive Health Services includes Coverage for Well-Child Care in accordance with the recommendations of the American Academy of Pediatrics.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Key preventive care includes:
 - Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sports, school, or camp activities.
 - Hearing and Vision screening for correction. This does not include routine eye exams or Eye Vision and Hearing screening to determine Refractions performed by eye care specialists. One Eye Refraction per Calendar Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases.
 - Pediatric Vision – Please refer to Exhibit A at the end of this Agreement for benefit coverage and details.
 - Behavioral Assessments
 - Screening for Alcohol and drug use, anemia, blood pressure, congenital hypothyroidism, depression, developmental development and surveillance, dyslipidemia, hematocrit/hemoglobin or sickle cell, lead, obesity, oral health, sexuality transmitted diseases, Phenylketonuria (PKU) and Tuberculin testing.



- Counseling from Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members under 19 years of age, this includes (as deemed appropriate by the Member's Practitioner/Provider or as requested by the parents or legal guardian) education information on Alcohol and Substance Use Disorder, sexually transmitted diseases, and contraception.

Preventive Health Services for Women

Preventive Services for Women include all Clinical Preventive Health Services discussed in this Benefits Section and those specific to Women.

- Well-woman visits to include adult and female-specific screenings and preventive benefits
- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
 - Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00143765.pdf Women's Preventative Services Contraceptives covered with No Copay.
- Counseling for HIV, sexually transmitted diseases and domestic violence and abuse.
- Domestic and interpersonal violence screening and counseling for all women.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- Human Papillomavirus (HPV) DNA Test: High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.

- HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast feeding counseling.
- Sexually Transmitted Infections (STI) counseling for sexually active women.
- Sterilization services for women only. Other services, performed during the procedure, are subject to deductible and coinsurance as outlined in your *Summary of Benefits and Coverage*.
- Well–woman visits to obtain recommended preventive services for women.



You can obtain additional information about Women's Preventive Services recommendations and guidelines on our website at www.phs.org and at the HealthCare.gov website at <http://www.healthcare.gov/prevention>.



Important
Information

➤ Complementary Therapies



Exclusion

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

- **Acupuncture**

- Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by your Practitioner/Provider.
- It is recommended that Acupuncture be part of a coordinated plan of care approved by your Practitioner/Provider.



Important
Information

- **Chiropractic Services**

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

- The Practitioner/Provider determines in advance that Chiropractic treatment can be expected to result in Significant Improvement in your condition within a period of two months.



Important
Information

- Chiropractic treatment is specifically limited to treatment by means of manual manipulation; i.e., by use of hands, and other methods of treatment approved by us including, but not limited to, ultrasound therapy.
- Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. We do not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment.



- **Biofeedback**

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

➤ **Dental Services (Limited)**



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

Exclusion



Refer to

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

- Accidental Injury to sound natural teeth, jawbones or surrounding tissue. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury and will not be Covered.**
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Hospitalization, day surgery, Outpatient and/or anesthesia for non-Covered dental services, are Covered, if provided in a Hospital or ambulatory surgical center for dental surgery, with our approval of a **Prior Authorization** request. Plan benefits for these services include coverage:
 - For Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
 - For Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.



**Prior Auth
Required**

- For Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
- For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- For other procedures for which Hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- **Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)**



**Prior Auth
Required**

The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) are subject to the same conditions, limitations, and require **Prior Authorization** as they apply to treatment of any other joint in the body.

➤ **Diabetes Services**



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

Exclusion

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

- **Diabetes Education (Limited).** The following benefits are available when received from a Practitioner/Provider who is approved to provide diabetes education:
 - Medically Necessary visits upon the diagnosis of diabetes
 - Visits following a Practitioner/Provider diagnosis that represents a significant change in condition or symptoms requiring changes in the patient's self-management

- Visits when re-education or refresher training is prescribed by a health care Practitioner/Provider with prescribing authority
- Telephonic visits with a Certified Diabetes Educator (CDE)
- Medical nutrition therapy related to diabetes management

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



- Diabetes supplies and services. The following equipment, supplies, appliances, and services are Covered when prescribed by your Practitioner/Provider and when obtained through the designated network Provider. These items require the use of approved brands and must be purchased at an In-network Pharmacy, Preferred vendor or Preferred Durable Medical Equipment (DME) supplier. Please contact our Presbyterian Customer Service Center from 7:00 am to 6:00 pm at **(505) 923-5678 or toll-free at 1-800-356-2219. TTY users may call 711.** You may also visit their website at www.phs.org for further information.

- Insulin pumps when Medically Necessary, prescribed by an In-network endocrinologist
- Specialized monitors/meters for the legally blind



- Medically Necessary Covered Podiatric appliances for prevention of feet complications associated with diabetes. Refer to the **Durable Medical Equipment Benefits Section.**
- Preferred Prescriptive diabetic oral agents for controlling blood sugar levels – Refer to your **Formulary** for Preferred agents
- Glucagon emergency kits
- Preferred Insulin - Refer to your **Formulary** for Preferred Insulin
- Syringes
- Injection aids, including those adaptable to meet the needs of the legally blind
- Preferred Blood glucose monitors/meters – Refer to your **Formulary** for Preferred monitors

- Preferred Test strips for blood glucose monitors – Refer to your **Formulary** for Preferred Test strips
- Preferred Lancets and lancet devices
- Visual reading urine and ketone strips

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



Exclusion

These benefits may have one or more exclusions as specified in the Exclusions section.



Refer to

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



Prior Auth
Required

- Examples of Covered procedures include, but are not limited to, the following:
 - Computerized Axial Tomography (CAT) scans – requires **Prior Authorization**
 - Magnetic Resonance Angiogram (MRA) tests, Magnetic Resonance Imaging (MRI) tests – require **Prior Authorization**
 - Sleep disorder studies in home or facility – requires **Prior Authorization**
 - Bone density studies
 - Clinical laboratory tests
 - Gastrointestinal lab procedures
 - Pulmonary function tests
 - Radiology/X-ray services

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



Exclusion

These benefits may have one or more exclusions as specified in the Exclusions section.

- **Durable Medical Equipment**



Prior Auth
Required

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

- **Orthotic Appliances**



Prior Auth
Required

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

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

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

- **Prosthetic Devices**



Prior Auth
Required

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

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

- breast prostheses when required because of mastectomy and prophylactic mastectomy
- artificial limbs
- prosthetic eye
- prosthodontic appliances
- penile prosthesis
- joint replacements

- heart pacemakers
- tracheostomy tubes and cochlear implants

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



**Prior Auth
Required**

- Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices requires **Prior Authorization**. Repair and replacement is Covered when Medically Necessary due to change in your condition, wear or after the product's normal life expectancy has been reached.
- One-month rental of a wheelchair is Covered if you owned the wheelchair that is being repaired.

- **Surgical Dressing**

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

- **Gradient compression stockings** are Covered for:

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

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



**Important
Information**

- **Eyeglasses and Contact Lenses (Limited)**

The following will only be Covered:

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

- **Hearing Aids**

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

- Every 36 months per hearing impaired ear for school-aged children under 18 years old (or under 21 years of age if still attending high school). Refer to your ***Summary of Benefits and Coverage*** for your Cost Sharing (Deductible, Coinsurance and/or Copayment) amount.
- Shall include fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by an In-network Practitioner/Provider licensed in New Mexico.

➤ **Employee Assistance Program**

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

➤ **Family, Infant and Toddler (FIT) Program**



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



➤ **Genetic Inborn Errors of Metabolism Disorders (IEM)**

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



Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the **Limitations, Exclusions, and Prior Authorization** requirements listed in this Agreement. Medical services provided by licensed Health Care

Professionals, including Practitioners/Providers, dieticians and nutritionists with specific training in managing Members diagnosed with IEM are Covered.

Covered Services include:

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



- Special Medical Foods are dietary items that are specially processed and prepared to use in the treatment of Genetic Inborn Errors of Metabolism to compensate for the metabolic abnormality and to maintain adequate nutritional status when we approve the **Prior Authorization request** and when provided under the on-going direction of a qualified and licensed health care Practitioner/Provider team.



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

➤ **Habilitative**

- **Autism Spectrum Disorder**

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

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

These services are **only Covered when a treatment plan is provided to our Health Services Department prior to services being obtained**. The Health Services Department will review the treatment plans in accordance with state mandated benefits.

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

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



Exclusion

Home Health Care Services/Home Intravenous Services and Supplies

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

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



**Prior Auth
Required**

- Any Practitioner's/Provider's prescription and **Prior Authorization** must be renewed at the end of each 60-day period. We will not impose a limitation on the number of related hours per visit.
- Home Health Care Services shall include Medically Necessary skilled intermittent Health Care Services provided by a registered nurse or a licensed practical nurse; physical, occupational, and/or respiratory therapist and/or speech pathologist. Intermittent Home Health aide services are only Covered when part of an approved plan of care which includes skilled services.
- Such services may include collection of specimens to be submitted to an approved laboratory facility for analysis.
- Medical equipment, Prescription Drugs and Medications, laboratory services and supplies deemed Medically Necessary by a Practitioner/Provider for the provision of health services in the home, except Durable Medical Equipment, will be Covered.
- The following Home Health Care Services will be Covered when we approve a **Prior Authorization** request:
 - Home health care or home intravenous services as an alternative to Hospitalization, as determined by your Practitioner/Provider
 - Total parenteral and enteral nutrition as the sole source of nutrition
 - **A Medical Drug** is any drug administered by a Health Care Professional and is typically given in the member's home, physician's office, freestanding (ambulatory)



**Prior Auth
Required**

infusion suite, or outpatient facility. Medical Drugs may require a Prior Authorization and some must be obtained through the specialty network.



- For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our In-network Specialty network, please visit the Presbyterian Pharmacy website at http://docs.phs.org/idc/groups/public/%40phs/%40php/documents/phscontent/pel_00052739.pdf. You may call our Presbyterian Customer Service Center for more information at **(505) 923-5678 or toll-free 1-800-356-2219** Monday through Friday from 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY number at 711**.

➤ Hospital Services - Inpatient



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

Exclusion

Inpatient means you have been admitted by a health care Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services are acute care services provided when you are a registered bed patient and there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital.



Prior Auth Required

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



Refer to

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

Inpatient Hospital benefits also includes Acute medical detoxification.

➤ Hyperbaric Oxygen Therapy



Prior Auth Required

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

➤ Infertility

Diagnosis and medically indicated treatments for physical conditions causing infertility.

➤ **Mental Health Services and Alcoholism and Substance Use Disorder Services**



Exclusion

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

- **Mental Health Services**

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



Refer to

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



Prior Auth
Required

- Acute medical detoxification benefits are Covered under Inpatient and Outpatient Medical services found in the Benefits Section. Some services require **Prior Authorization**.

- **Alcohol and Substance Use Disorder Services**

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



Prior Auth
Required

- For Out-of-network Services, Members need to contact our Behavioral Health Department in order to obtain Prior Authorization, when required. Please refer to the **Prior Authorization Section**.
- In all cases, treatment must be Medically Necessary in order to be Covered.
- Acute Medical Detoxification Benefits are Covered under Inpatient and Outpatient Hospital Services found in the Benefits Section of this Agreement. Inpatient Hospital Services must be **Prior Authorized**.



Exclusion

➤ **Nutritional Support and Supplements**

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

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



**Prior Auth
Required**

- Nutritional supplements that require a prescription to be dispensed are Covered when prescribed by an In-network Practitioner/Provider and when Medically Necessary to replace a specific documented deficiency. **Prior Authorization is required.**
- Nutritional supplements administered by injection at the Practitioner's/Provider's office are Covered when Medically Necessary.
- Enteral formulas or products, as Nutritional support, are Covered only when prescribed by an In-network Practitioner/Provider and administered by enteral tube feedings.
- Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is Covered when ordered by an In-network Practitioner/Provider.
- Special Medical Foods as listed as Covered benefits in the Genetic Inborn Errors of Metabolism (IEM) Benefit of this Section. **Prior Authorization is required.**

➤ **Outpatient Medical Services**



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

Exclusion

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



Refer to

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



Refer to

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

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

- Chemotherapy and radiation therapy - Chemotherapy is the use of chemical agents in the treatment or control of disease.



Important
Information

- Hypnotherapy (**Limited**) - Hypnotherapy is only Covered when performed by an anesthesiologist or psychiatrist, trained in the use of hypnosis when:
 - Used within two weeks prior to surgery for chronic pain management and
 - For chronic pain management when part of a coordinated treatment plan.



Refer to

- Dialysis
- Diagnostic Services – Refer to the **Diagnostic Services** Section
- Acute Medical Detoxification: Medically Necessary Services for Substance Use Disorder detoxification



Prior Auth
Required

- **A Medical Drug** is any drug administered by a Health Care Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a Prior Authorization and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require Prior Authorization and what drugs are mandated to our Specialty network, please visit the **Presbyterian Pharmacy website at http://docs.phs.org/idc/groups/public/%40phs/%40php/documents/phscontent/pel_00052739.pdf**

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



Refer to

- Observation following Outpatient Services
- Sleep disorder studies, in home or outpatient facility. Refer to your ***Summary of Benefits and Coverage*** for Cost Sharing amounts
- Surgery
- Therapeutic and support care services, supplies, appliances, and therapies
- Wound care



Exclusion

➤ Practitioner/Provider Services

These benefits have one or more exclusions as specified in the Exclusions section.

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

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



Refer to

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

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

- Outpatient surgery and Inpatient surgery including necessary anesthesia services. Hypnotherapy is covered as part of anesthesia preparation.
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care
- Allergy Services, including testing and sera
- FDA approved contraceptive devices and prescription drugs excluding Over-the-Counter (OTC) items, unless a Covered OTC medication is on the Preferred Drug Listing, and investigational devices/ medications
- Sterilization procedures
- Student Health Centers: Dependent Students attending school either in New Mexico or outside New Mexico may receive care through their Primary Care Physician or at the Student Health Center. A Prior Authorization is not needed prior to receiving care from the Student Health Center. Services provided outside of the Student Health Center are limited to Medically Necessary Covered services for the initial care or treatment of an Emergency Health Care Service or Urgent Care situation.



Important
Information

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



➤ Prescription Drugs/Medications

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

Exclusion

- **Covered Prescription Drugs/Medications**



Refer to

The following drugs are Covered when prescribed by a Practitioner/Provider and when purchased through an In-network Pharmacy. Refer to your ***Formulary*** for information on the approved Prescription Drugs/Medications.



Refer to

- Medically Necessary prescription nutritional supplements for prenatal care when prescribed by the attending Practitioner/Provider for up to a 90-day supply up to the maximum dosing recommended by the manufacturer. Refer to your ***Summary of Benefits and Coverage*** for the Cost Sharing amount.
- Preferred insulin and diabetic oral agents for controlling blood sugar levels as prescribed by your Practitioner/Provider for up to a 90-day supply up to the maximum dosing recommended by the manufacturer. Refer to your ***Summary of Benefits and Coverage*** for the Cost Sharing amount.
- Immunosuppressant drugs following transplant surgery as prescribed by your Practitioner/Provider for up to a 90-day supply up to the maximum dosing recommended by the manufacturer. Refer to your ***Summary of Benefits and Coverage*** for the Cost Sharing amount.
- Special Medical Foods used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require **Prior Authorization**. Refer to **IEM in this Section** and your ***Summary of Benefits and Coverage*** for more information about Cost Sharing amount.
- Smoking Cessation Pharmacotherapy. Prescription Drugs/Medications as prescribed by your Practitioner/Provider for up to a 90-day supply up to the maximum dosing recommended by the manufacturer purchased at an In-network Pharmacy limited to two 90-day courses of treatment per Calendar Year. Refer to the **Covered Prescription Drugs/Medications** in your ***Summary of Benefits and Coverage*** for your Cost Sharing amounts.
- FDA-approved Contraceptive Prescription Drugs/Medications and devices without Cost Sharing when prescribed by a Practitioner/Provider. Over-the-counter items



**Prior Auth
Required**

are **excluded** unless they are listed as a Covered OTC medication/device on our **Formulary**.

Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at

http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00143765.pdf

Women's Preventive Services contraceptives covered with no copay

- **Prescription Drugs/Medications Benefit (Outpatient) – if applicable**



Outpatient Prescription Drugs/Medications, including FDA approved contraceptives and devices, are a Covered Benefit when prescribed by your Practitioner/Provider for a medically appropriate use and when purchased through an In-network Pharmacy. Refer to your **Formulary** for information on the approved Prescription Drugs/Medications.



For each Prescription Drug/Medication purchased at our In-network Pharmacy, one applicable Preferred Generic, Preferred Brand or Non-Preferred Drug Cost Sharing Amount will be required for a 30-day supply up to the maximum dosing recommended by the manufacturer/FDA. A generic equivalent will be dispensed if available.

If you or your healthcare provider requests a brand name drug when a generic equivalent is available, you pay the difference in price between brand and generic, plus the applicable brand cost-sharing amount.

- Schedule II Medications are limited to a maximum of 34-day dispensing.
- Vacation overrides require Prior Authorization. A maximum of one 30 day override per medication per benefit/calendar year.
- **Specialty Pharmaceuticals Tier 4:** Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or care-giver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life threatening conditions. Most Specialty Pharmaceuticals require **Prior Authorization** and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than \$600 for a 30 day supply.
- **Specialty Pharmaceuticals** are not available through the mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill up to a 14-day supply to ensure patients can tolerate the new medication. The medications listed on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan.

- Some specialty medications may qualify for third-party copayment assistance programs which could lower your out-of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the Member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

- **Prescription Drugs/Medications – Up to a 90-Day supply:**

You have the option to purchase up to a 90-day supply of Prescription Drugs/Medications. Under the up to a 90-day at Retail Pharmacy benefit, Preferred Generic, Preferred Brand and Non-Preferred Prescription Drugs/Medications can be obtained from an In-network Pharmacy. You will be charged three applicable Copayments for a 90-day supply up to the maximum dosing recommended by the manufacturer/FDA. Copayments are as follows:



- ◆ Three (3) 30-day Cost Sharing Copayments at the applicable Tier copayment. Refer to your *Summary of Benefits and Coverage* and *Pharmacy Drug Rider* for your Cost Sharing amounts.



Certain Prescription Drugs/Medications may not be purchased through a retail pharmacy, such as medications on the Specialty Pharmaceutical Listing. Specialty pharmaceuticals are limited to a 30-day supply.

Drug Utilization Review (DUR) and Drug Use Evaluation Programs

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

Generic

A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Brand-Name Drugs When a Generic Equivalent is Available

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

If Medical Necessity is established the non-preferred drug copay or Specialty drug copayment will be applied. Otherwise, brand-name drugs when a generic is equivalent is available are not Covered and will not count towards the deductible or annual out-of-pocket maximums.

What is Prior Authorization?

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

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

- Continuation of therapy using any drug is dependent upon its demonstrable efficacy.
- Note that the prior use of free prescription medications (ie. Samples, free goods, etc) will not be considered in the evaluation of a member's eligibility for medication coverage.

- **Mail Order Pharmacy**



Call PCSC
505-923-5678
1-800-356-2219

You have a choice of obtaining certain Prescription Drugs/Medications directly from a Pharmacy or by ordering them through the mail. Under the mail order pharmacy benefit, Preferred and Non-Preferred medications can be obtained through the Mail Order Service Pharmacy. You may purchase up to a 90-day supply up to the maximum dosing recommended by the manufacturer. You may obtain more information on the Mail Service Pharmacy by calling our Presbyterian Customer Service Center at **(505) 923-5678 or toll-free 1-800-356-2219** Monday through Friday from 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY number at 711** or by visiting the Pharmacy page of our website at www.phs.org. Copayments are as follows for mail order pharmacy:



Refer to

- Cost Sharing Copayments at the applicable Tier Copayment. Refer to your ***Summary of Benefits and Coverage*** and **Pharmacy Drug Rider** for your Cost Sharing amounts.



Certain drugs may not be purchased by mail order, such as Prescription Drugs/Medications on the Specialty Pharmaceutical Listing.

• **Member Reimbursement**

If a medical Emergency occurs outside of our Service Area and you use an In-network Pharmacy, you will be responsible for payment of the appropriate Copayment. We have a large, comprehensive pharmacy network; however, if you go to an Out-of-network Pharmacy, and they are unable to process the claim at point of service you can pay for the prescription and submit a *Member Reimbursement Form*. Reimbursement will be based on the negotiated rate between Presbyterian Health Plan and the dispensing pharmacy minus any copay or coinsurance that may apply. The form together with the itemized cash register receipt and the prescription drug detail (pharmacy pamphlet) must contain the following information:

- Patient's name
- Patient's Date of Birth
- Name of the drug
- Quantity dispensed
- NDC (National Drug Code)
- Fill Date
- Name of Prescriber
- Name and phone number of the dispensing pharmacy
- Reason for the purchase (nature of emergency)
- Proof of Payment (copy of the check, credit card statement or a receipt showing that payment in full was received)



Member Reimbursement forms are available by calling our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or 1-800-356-2219**. Hearing impaired users may call our **TTY number at 711** or visit the Pharmacy page of our website at www.phs.org.



➤ **Reconstructive Surgery**

Exclusion

This benefit includes one or more exclusions as specified in the Exclusions section.



Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be Covered if performed for the correction of functional disorders. Reconstructive Surgery must be prescribed by a Member's Practitioner/Provider and requires **Prior Authorization**. For information regarding Reconstructive Surgery following a Mastectomy and Prophylactic Mastectomy, refer to the **Women's Health Care Section**.



Rehabilitation and Therapy

Exclusion

This benefit includes one or more exclusions as specified in the Exclusions section.

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



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



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



- Outpatient physical and occupational therapy require that your Primary Care Practitioner or other appropriate treating Practitioner/Provider must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in your condition. Refer to your *Summary of Benefits and Coverage* for your visit limitations.



Prior Auth
Required

- The treatment plans that define expected Significant Improvement must be established at the initial visit. Therapy treatments must be provided and/or directed by a licensed physical or occupational therapist.
- Treatments by a physical or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist.
- Massage Therapy is only Covered when provided by a licensed physical therapist and as part of a prescribed Short-term Rehabilitation physical therapy program.



Refer to

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



Call PCSC
505-923-5678
1-800-356-2219

- Your Primary Care Physician must determine, in advance, in consultation with us, that speech therapy can be expected to result in Significant Improvement in your condition. Refer to your ***Summary of Benefits and Coverage*** for your visit limitations and Cost Sharing.



Refer to

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

➤ Skilled Nursing Facility Care



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

Exclusion

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



Refer to

- Refer to your *Summary of Benefits and Coverage* for your visit limitations.

➤ Smoking Cessation Counseling/Program



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

Exclusion

- Coverage is provided for Diagnostic Services, Smoking Cessation Counseling and pharmacotherapy. Medical services are provided by licensed Health Care Professionals with specific training in managing your Smoking Cessation Program. The program is described as follows:
 - Individual counseling at an In-network Practitioner's/Provider's office is Covered under the medical benefit. The Primary Care Practitioner or the In-network specialist Copayment applies.
 - Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Practitioner/Provider. No Cost Sharing will apply and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.

- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. You may want to utilize these services.

For more information contact our Presbyterian Customer Service Center at **(505) 923-5678 or toll-free at 1-800-356-2219**, Monday through Friday from 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY line at 711**.

Pharmacotherapy benefit Limitations

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



Refer to your ***Summary of Benefits and Coverage*** and your ***Formulary*** for your Cost Sharing amount.

➤ **Transplants**



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

Exclusion

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



Prior Auth Required

- Human Solid Organ transplant benefits are Covered for:
 - kidney
 - liver
 - pancreas
 - intestine
 - heart
 - lung
 - multi-visceral (3 or more abdominal Organs)
 - simultaneous multi-Organ transplants – unless investigational
 - pancreas islet cell infusion
- Meniscal Allograft

- Autologous Chondrocyte Implantation – knee only
- Bone Marrow Transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are Covered for the following indications:
 - multiple myeloma
 - leukemia
 - aplastic anemia
 - lymphoma
 - severe combined immunodeficiency disease (SCID)
 - Wiskott Aldrich syndrome
 - Ewing's Sarcoma
 - germ cell tumor
 - neuroblastoma
 - Wilms Tumor
 - myelodysplastic Syndrome
 - myelofibrosis
 - sickle cell disease
 - thalassemia major



- If there is a living donor that requires surgery to make an Organ available for a Covered transplant for our Member, Coverage is available for expenses incurred by the living donor for surgery, laboratory and X-ray services, Organ storage expenses, and Inpatient follow-up care only. We will pay the Total Allowable Charges for a living donor who is not entitled to benefits under any other health benefit plan or policy.
- **Limited** travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be Covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be Covered for both out-of-state and in-state, up to a maximum of \$150 per day for the transplant recipient, live



**Prior Auth
Required**

donor and one other person combined. Benefits will only be Covered for transportation, lodging and meals and are **limited** to a lifetime maximum of \$10,000. All Organ transplants must be performed at site that we approve and require **Prior Authorization**.

➤ **Women's Health Care**



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

Exclusion



**Prior Auth
Required**

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

- Gynecological care includes:
 - Annual exams
 - Care related to pregnancy
 - Miscarriage
 - Therapeutic abortions
 - Elective abortions up to 24 weeks
 - Other gynecological services
- **Prenatal Maternity** care benefits include:
 - Prenatal care
 - Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between sixteen and twenty weeks of pregnancy, to screen for certain abnormalities in the fetus)
 - Visits to an Obstetrician
 - Certified Nurse-midwife
 - Midwife
 - Medically Necessary nutritional supplements as determined and prescribed by the attending Practitioner/Provider. Prescription nutritional supplements require **Prior Authorization**.



**Prior Auth
Required**

- Childbirth in a Hospital or in a licensed birthing center

- **Maternity care**

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

- Maternity Coverage is available to a mother and her newborn (if a Member) for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. Maternity In-patient Hospital admissions and birthing center admissions require notification to appropriately manage care.
- In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her attending Practitioner/Provider. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists including, but not limited to, the criterion that family Members or other support person(s) will be available to the mother for the first few days following early discharge.
- Maternity Inpatient care in excess of 48 hours following a vaginal delivery and 96 hours following a cesarean section will be Covered if determined to be Medically Necessary by the mother's attending Practitioner/Provider. An additional stay will be considered a separate Hospital stay and requires **Prior Authorization**. Refer to your ***Summary of Benefits and Coverage*** for Cost Sharing information.
- High-risk Ambulance services are Covered in accordance with the **Ambulance Services Benefits Section**.
- The services of a Midwife or Certified Nurse Midwife are Covered, for the following:
 - ◆ The midwife's services must be provided strictly according to their legal scope of practice and in accordance with all applicable state licensing regulations which may include a supervisory component.
 - ◆ The services must be provided in preparation for or in connection with the delivery of a newborn.
 - ◆ For purpose of Coverage under this Agreement, the only allowable sites of delivery are a Hospital or a licensed birthing center. Elective Home Births and any prenatal or postpartum services connected with Elective Home Births are



not Covered. Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

- ◆ The combined fees of the midwife and any attending or supervising Practitioners/Providers, for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Practitioner/Provider had he/she been the sole Practitioner/Provider of those services.

- **Newborn Care**

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



Timeframe
associated
with this item

- ◆ We must receive the signed and completed enrollment Application for the newborn that was submitted to the employer Group within **31 days** from the date of birth.
- ◆ If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed enrollment Application within the first **31 days** following the date of birth.
- ◆ If the above conditions are not met, we will not enroll the newborn for Coverage until the next Annual Group Enrollment Period.
- ◆ Neonatal care is available for the newborn of a Member for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a Cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, it is considered a separate Hospital stay and requires **Prior Authorization**. Refer to your *Summary of Benefits and Coverage* for your Cost Sharing amount.
- ◆ Benefits for a newborn who is a Member shall include Coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Where necessary to protect the life of the infant Coverage includes transportation, including air Ambulance Services to the nearest available Tertiary facility. Newborn Member benefits also include Coverage for newborn visits in the Hospital by the baby's Practitioner/Provider, circumcision, incubator, and routine Hospital nursery charges.
- ◆ A newborn of a Member's Dependent child **cannot** be enrolled unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by the court as the newborn's legal guardian.

➤ **Additional Women's Health Care Benefits**

- Mammography Coverage.



**Prior Auth
Required**

- Mastectomy, Prophylactic Mastectomy, Prosthetic Devices and Reconstructive surgery. All care requires **Prior Authorization**.



Refer to

- ◆ Coverage for Medically Necessary surgical removal of the breast (mastectomy) is for not less than 48 hours of Inpatient care following a mastectomy and not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless you and the attending Practitioner/Provider determine that a shorter period of Hospital stay is appropriate.
- ◆ Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer is subject to Cost Sharing amounts consistent with those imposed on other benefits. Refer to your ***Summary of Benefits and Coverage*** for Cost Sharing amounts.
- ◆ Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). Two bras per year are Covered for Members with external breast prosthesis.
- ◆ As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.
- ◆ Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy.
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- The Alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks for pregnancy, to screen for certain genetic abnormalities in the fetus.
- Coverage for the preventive screening of women who have family members with breast, ovarian, tubal or peritoneal cancers with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2).

- ◆ Women with positive screening results may receive genetic counseling and, if indicated after counseling, BRCA testing as determined by her health care provider.

GENERAL LIMITATIONS

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

Benefit Limitations

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

- Some Benefits may be subject to dollar amount and/or visit **limitations**.
- Benefits may be **excluded** if the services are provided by Out-of-network Practitioners/Providers.
- Some Benefits may be subject to **Prior Authorization**.



Refer to

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

Coverage while away from the Service Area

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

Major Disasters

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

Prior Authorization

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

EXCLUSIONS

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

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

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

➤ **Emergency Health Care Services**

Use of an emergency facility for non-emergent services is not Covered.

➤ Non-emergency care when traveling outside the U.S.

Ambulance Services

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

Autopsies

Autopsy costs for deceased Members are not Covered.

Before or After the Effective Date of Coverage

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

Clinical Trials

- Any Clinical Trials provided outside of New Mexico, as well as those that do not meet the requirements indicated in the Benefits Section, are not Covered.
- Costs of the Clinical Trial that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources are not Covered.



**Prior Auth
Required**

- Services from Out-of-network Practitioners/Providers, unless services from an In-network Practitioner/Provider is not available are not Covered. **Prior Authorization** is required for any Out-of-network Services and such services must be provided for in New Mexico.
- The cost of a non-FDA approved Investigational drug, device or procedure is not Covered.
- The cost of a non-health care service that the patient is required to receive as a result of participation in the Clinical Trial is not Covered.
- Costs associated with managing the research that is associated with the Clinical Trials are not Covered.
- Costs that would not be Covered if non-Investigational treatments were provided are not Covered.
- Costs of tests that are necessary for the research of the Clinical Trial are not Covered.
- Costs paid for or not charged by the Clinical Trial Providers are not Covered.

Care for military service connected disabilities

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

Certified Hospice Care benefits are not Covered for the following services.

- Food, housing, and delivered meals are not Covered.
- Volunteer services are not Covered.
- Personal or comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits) are not Covered.
- Homemaker and housekeeping services are not Covered.
- Private duty nursing is not Covered.
- Pastoral and spiritual counseling are not Covered.
- Bereavement counseling is not Covered.
- The following services are not Covered under Hospice care, but may be **Covered Benefits elsewhere in this Agreement** subject to the Cost Sharing requirements:

- Acute Inpatient Hospital care for curative services – requires **Prior Authorization**
- Durable Medical Equipment
- Practitioner/Provider visits by other than a Certified Hospice Practitioner/Provider
- Ambulance Services

Charges in excess of Medicare Allowable

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

Clothing or other protective devices

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

Clinical Preventive Health Services

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

Complementary Therapies

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

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

➤ **Biofeedback**

- Except as specified under Complementary Therapies in the Benefits Section.

Cosmetic Surgery

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

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



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

Cosmetic treatments, devices, Orthotics, and Prescription Drugs/Medications

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

Costs for extended warranties and premiums for other insurance coverage

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

Dental Services (over age 19)

- Dental care and dental X-rays are not Covered, except as provided in the **Benefits Section**
- Dental implants are not Covered
- Malocclusion treatment, if part of routine dental care and orthodontics, is not Covered.
- Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are not Covered, unless the disorder is trauma related.

Diabetes Services

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

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

➤ Durable Medical Equipment

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

➤ Repair and Replacement

- Repair or replacement of Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience is not Covered.
- Repair and replacement of items under the manufacturer or supplier's warranty are not Covered.
- Additional wheelchairs are not Covered, if the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair.

➤ Orthotic Appliances

- Functional foot Orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs and other conditions (as we determine), Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints are not Covered, except for patients with diabetes or other significant peripheral neuropathies.
- Custom-fitted Orthotics/Orthosis are not Covered except for knee-ankle-foot (KAFO) Orthosis and/or ankle-foot Orthosis (AFO) except for Members who meet national recognized guidelines.

➤ **Prosthetic Devices**



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

➤ **Surgical Dressing**

- Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, adhesive bandages, gauze (such as 4 by 4's), and elastic wrap bandages are not Covered, except when provided in a Hospital or Practitioner's/Provider's office or by a home health professional.
- Gloves are not Covered, unless part of a wound treatment kit.
- Elastic Support hose are not Covered.

➤ **Eyeglasses and Contact Lenses (over age 19)**



- Routine vision care and Eye Refractions for determining prescriptions for corrective lenses are not Covered, except as identified in the **Benefits** Section.
- Corrective eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, are not Covered except as identified in the **Benefits** Section.
- Eye refractive procedures including radial keratotomy, laser procedures, and other techniques are not Covered.
- Visual training is not Covered.
- Eye movement therapy is not Covered.

➤ **Exercise equipment, Personal Trainers, Club Memberships**

Exercise equipment, videos, personal trainers, club membership (unless optional rider purchased by Employer Group), and weight reduction programs are not Covered

Experimental or Investigational drugs, medicines, treatments, procedures, or devices are not Covered.

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

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or

- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by state law, the drug or device is used for a purpose that is not approved by the FDA; or
- For the purposes of this section, “reliable evidence” shall mean only published reports and articles in the authoritative medical and scientific literature listed in state law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, “Experimental” or “Investigational” does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

Extracorporeal shock wave therapy

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

Foot Care

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

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



- Food substitutes for lactose intolerance or other carbohydrate intolerances, including soy foods or elemental formulas or other Over-the-counter (OTC) digestive aids are not Covered, unless listed as a Covered Over-the-counter (OTC) medication on our *Formulary*.
- Ordinary food that might be part of an exclusionary diet are not Covered.

- Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM are not Covered.
- Special Medical Foods for conditions that are not present at birth are not Covered.
- Dietary supplements and items for conditions including, but not limited to, Diabetes Mellitus, Hypertension, Hyperlipidemia, Obesity, Autism Spectrum Disorder, Celiac Disease and Allergies to food products are not Covered.

Hair-loss (or baldness)

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

Home Health Care Services/Home Intravenous Services and Supplies

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

Hospital Services

- Acute Medical Detoxification in a Residential Treatment Center is not Covered.
- Rehabilitation is not Covered as part of acute medical detoxification.

Mental Health and Alcoholism and Substance Use Disorder

- Mental Health
 - Alcohol and/or Substance Use Disorder services are not considered mental health benefits.
 - Bereavement, pastoral/spiritual and sexual counseling are not Covered.
 - Codependency treatment is not Covered.
 - Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy is not Covered.



- Psychological testing when not Medically Necessary is not Covered.
 - Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems are not Covered. This applies whether or not associated with manifest mental illness or other disturbances except as Covered under the Family, Infant and Toddler Program. Refer to the **Benefits Section**.
- Alcoholism Services and Substance Use Disorder Services
- Treatment in a halfway house is not Covered.
 - Codependency treatment is not Covered.
 - Court-ordered treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Use Disorder programs, is not Covered.
 - Any treatment for Alcoholism and/or Substance Use Disorder services after the maximum episodes of treatment allowed under this Agreement have been completed is not Covered.

Nutritional Support and Supplements

Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system for oral or tube feedings is not Covered.

Prescription Drugs/Medications

- Prescription Drugs/Medications that require a Prior Authorization when Prior Authorization was not obtained are not Covered.
- New Prescription Drugs/Medications for which the determination of criteria for Coverage has not yet been established by our Pharmacy and Therapeutics Committee are not Covered.
- Prescription Drugs/Medications purchased outside the United States are not Covered.
- Prescription Drugs/Medications, medicines, treatments, procedures, or devices that we determine are Experimental or Investigational are not Covered.
- Prescription Drugs/Medications that have not been approved by the FDA are not Covered.
- Prescription Drugs/Medications that are identified by Drug Efficacy Study Implementation (DESI) as Less than Effective (LTE) DESI drugs are not Covered.
- Replacement Prescription Drugs/Medications resulting from loss, theft, or destruction are not Covered.

- Disposable medical supplies, except when provided in a Hospital or a Practitioner's/Provider's office or by a home health professional, are not Covered.
- Prescription Drugs/Medications used in conjunction with In-vitro fertilization and artificial insemination are not Covered
 - Oral or injectable medications used to promote pregnancy are not Covered.
- Over-the-counter (OTC) medications and drugs are not Covered. Refer to our **Formulary** for a list of Covered Over-the-counter (OTC) medications as determined by our Pharmacy and Therapeutics Committee.
- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are not Covered.
- Prescription Drugs/Medications for the purpose of weight reduction or control, except for Medically Necessary treatment for morbid obesity, are not Covered.
- Prescription Drugs/Medications used for cosmetic purposes are not Covered.
- Nutritional supplements as prescribed by the attending Practitioner/Provider or as sole source of nutrition are not Covered.
 - Infant formula is not Covered under any circumstance
- Compounded Prescription Drugs/Medications are not Covered.
 - Bulk powders are not Covered.
- Discount Cards or prescription Drug Savings Cards do not apply to Deductible or Out of Pocket Maximums unless Medical Necessity has been established.
 - Herbal or alternative medicine and holistic supplements are not Covered.
 - Vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, or functional capacity examinations related to employment are not Covered
 - Immunizations for the purpose of foreign travel, flight and or passports are not Covered.
 - Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy including “all-natural” pills, creams, lotions and gels are Not Covered.

LDAA Local Delivery of Antimicrobial Agents used for Periodontal Procedures are Not Covered.

Practitioner/Provider Services



- Services provided by an Excluded Provider are not Covered. Any benefit or service, including pharmaceuticals, provided by an Excluded Provider as defined and maintained by the following regulatory agencies: Department of Health and Human Services; Office of the Inspector General (OIG); U.S. Department of Health; the General Services Administration; and the Office of Personnel Management, Office of Inspector General, which includes, but is not limited to, the:
 - Excluded Parties Lists System (EPLS),
 - List of Excluded Individuals/Entities (LEIE),
 - Office of Personnel Management (OPM).
- **Office Visits**, listed below, are not Covered.
 - Electronic mail (e-mail) by a Practitioner/Provider or consultation by telephone for which a charge is made to the patient, is not Covered.
 - Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided are not Covered.
- **Infertility services**, listed below, are not Covered.
 - Prescription Drugs and Injections
 - Reversal of voluntary sterilization is not Covered.
 - Donor sperm is not Covered.
 - In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization are not Covered.
 - Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue is not Covered.

Reconstructive Surgery for Cosmetic purposes is not Covered

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

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

Rehabilitation and Therapy, as listed below, is not Covered

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

- Athletic trainers or treatments delivered by Athletic trainers are not Covered.
- Vocational Rehabilitation Services are not Covered.
- Long-term Therapy or Rehabilitation Services are not Covered. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered Long-term Rehabilitation when:
 - You have reached maximum rehabilitation potential.
 - You have reached a point where Significant Improvement is unlikely to occur.
 - You have had therapy for four consecutive months.

Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, Cerebral Palsy, Autism, and Developmental Delays not associated with a defined event of illness or injury.

- Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down syndrome, and Cerebral Palsy.

➤ **Speech Therapy services listed below are not Covered.**

- Therapy for stuttering is not Covered.
- Hearing Aids and the evaluation for the fitting of Hearing Aids are not Covered, except for school aged children under 18 years old (or under 21 years of age if still attending high school).
- Additional benefits beyond those listed in the **Speech Therapy Benefit** Section are not Covered.



Services for which you or your Dependent are eligible under any governmental program

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

Services requiring Prior Authorization when Out-of-network



If you fail to obtain **Prior Authorization** for services received Out-of-network that require **Prior Authorization**, those services are not Covered. However, Members are not liable when an In-network Practitioner/Provider does not obtain Prior Authorization. Refer to **Prior Authorization Section** for specific information.

Sexual dysfunction treatment



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

Skilled Nursing Facility Care

Custodial or Domiciliary care is not Covered.

Smoking Cessation services listed below are not Covered.

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



Thermography Services are not Covered.

Transplant Services listed below are not Covered.

- Non-human Organ transplants, except for porcine (pig) heart valve, are not Covered.
- Transportation costs for deceased Members are not Covered.
- The medical and Hospital services of an Organ transplant donor when the recipient of an Organ transplant is not a Member or when the transplant procedure is not a Covered Benefit are not Covered.



- Travel and lodging expenses are not Covered except as provided in the **Benefits Section**.

Treatment while incarcerated

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

Women's Health Care

- Elective abortions after the 24th week of pregnancy are not Covered.
- Maternity and newborn care, as follows, are not Covered:
 - Use of an emergency facility for non-emergent services is not Covered.
 - Elective Home Birth and any prenatal or postpartum services connected with an Elective Home Birth are not Covered. Allowable sites for a delivery of a child are Hospitals and licensed birthing centers. Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

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

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

CLAIMS

Your health care benefits are paid according to the conditions outlined in this Section. If you paid Practitioners/Providers for services, this Section also outlines the process you should follow if you need to be reimbursed.



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

Notice of Claim



Timeframe
associated
with this item

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

Claim Forms

You may call or write to us to notify us of a claim. Upon receipt of a notice of claim, we will furnish you with the forms needed for filing proof of service. Forms will be furnished within 15 days after we receive such notice. You may access our web site, www.phs.org to obtain a claim form.

In-network Practitioners/Providers

We pay In-network Practitioners/Providers directly for Covered Services they provide to you. You should not be required to pay sums to any In-network Practitioner/Provider except for the required Cost Sharing amount. You will be responsible for the payment of charges for missed appointments or appointments cancelled without adequate notice.



If you are asked by an In-network Practitioner/Provider to make any payments in addition to the Cost Sharing amount specified in this Agreement, you should consult our Presbyterian Customer Service Center at **(505) 923-5678 or toll-free at 1-800-356-2219**, Monday through Friday from 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY line at 711** before making any such additional payments. You will not be liable to an In-network Practitioner/Provider for any sums that we owe to the Practitioner/Provider.

Out-of-network Practitioners/Providers

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



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

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

Procedure for Reimbursement- Covered Medical Benefits



Timeframe
associated
with this item

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



Call PCSC
505-923-5678
1-800-356-2219

If you need a claim form or have questions regarding a charge made by your Practitioner/Provider, please contact our Presbyterian Customer Service Center at **(505) 923-5678 or toll-free at 1-800-356-2219**, Monday through Friday from 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY line at 711**. Claim forms are also available on our website at www.phs.org.

Please submit your completed claim form to:

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

Services Received Outside the United States



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

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

Claim Fraud



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

EFFECTS OF OTHER COVERAGE

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

Coordination of Benefits

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

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

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

- Employee/Dependent Rule
 - The plan, which covers you as an employee, pays first.
 - The plan, which covers you as a Dependent, pays second.
- Birthday Rule for Dependent children of parents who are not separated or divorced
 - The plan, which covers the parent whose birthday falls earlier in the year, pays first. The plan, which covers the parent whose birthday falls later in the year, pays second. The birthday order is determined by the month and the day of birth, not the year of birth.
 - If both parents have the same month and day of birth, the plan that Covered the parent longer, will pay claims first. The plan which covered the parent for a shorter period of time pays second.
- Dependent children of separated or divorced parents
 - The plan of the parent decreed by a court of law to have responsibility for medical coverage pays first.

- In the absence of a court order:
 - The plan of the parent with physical custody of the child pays first.
 - The plan of the Spouse of the parent with physical custody (i.e., the stepparent) pays second.
 - The plan of the parent not having physical custody of the child pays third.
- Active/Inactive Employee
 - The plan, which covers you as an active employee (or Dependent of an active employee), pays first.
 - The plan, which covers you as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.
- Longer/Shorter Employment
 - In the case where you are the Subscriber under more than one group health insurance policy, then the plan that has Covered you for a longer period of time will pay first. A change of insurance carrier by the group employer does not constitute the start of a new plan.
- No Coordination Provision
 - In spite of the rules listed above, the plan that has no provision regarding coordination of benefits will pay first.
- If you are covered under a motor vehicle or homeowner's insurance policy which provides benefits for medical expenses resulting from a motor vehicle accident or accident in your own home, you shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are covered by the motor vehicle or home owner's insurance policy. If we have provided such benefits, we shall have the right to recover any benefits we have provided from you or from the motor vehicle or homeowner's insurance to the extent they are available under the motor vehicle or homeowner's insurance policy.
- If you or your Dependents are Covered by COBRA continuation and are also Covered by another group plan, you shall receive our Covered Benefits to the extent that we will be secondary payer of all eligible charges, subject to the terms, conditions, **exclusions** and **limitations** of this Agreement.

In no event shall the Covered Benefits received under this Agreement and all other plans combined exceed the total reasonable actual expenses for the services provided under this Agreement.

For purposes of coordination of benefits,

- We may release, request, or obtain claim information from any individual or organization. In addition, any Member claiming benefits from us shall furnish us with any information which we may require.
- We have the right, if we make overpayments because of your failure to report other coverage or any other reason, to recover such excess payment from any individual to whom, or for whom, such payments were made.
- We will not be obligated to pay for non-Covered Services or Covered Benefits not obtained in compliance with our policies and procedures.

Medicare

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

Medicaid

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

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

Subrogation (Recovering Health Care Expenses from Others)

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

- By way of illustration only, our right of subrogation includes, but is not limited to, the right to be repaid when you recover money for personal injury sustained in a car accident. The subrogation right applies whether you recover directly from the wrongdoer or from the wrongdoer's insurer, or from your uninsured motorist insurance coverage. You agree to sign and deliver to us such documents and papers as may be necessary to protect our subrogation right. You also agree to keep us advised of:
 - Any claims or lawsuits made against any person, firm or entity responsible for any injuries for which we have paid Covered Benefits.
 - Any claim or lawsuit against any insurance company, or uninsured or underinsured motorist insurance carrier.
- Settlement of a legal claim or controversy without prior notice to us is a violation of this Agreement. In the event you fail to cooperate with us or take any other action, through agents or otherwise, which interferes with the exercise of our subrogation right, we may have, and hereby expressly reserve, all legal remedies available to us.
- When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both you and us, we will, upon request by you or your attorney, share such collection costs and legal expenses, in a manner that is fair and equitable, but only if we receive appropriate documentation of such collection costs and legal expenses.

SUMMARY OF HEALTH INSURANCE GRIEVANCE PROCEDURES

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

What types of decisions can be reviewed?

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

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

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

Review of an Adverse Determination

How does pre-authorization for a health care service work?

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

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

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

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

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

How long does initial certification take?

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

What if I need services in a hurry?

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

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

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

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

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

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

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

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

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

Telephone: (505) 923-5678 or 1-800-356-2219
Address: Presbyterian Health Plan
Attn: Appeals and Grievance Department
PO Box 27489 Albuquerque, NM 87125-7489
Fax #: (505) 923-5124
Email: info@phs.org.

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

Telephone: (505) 827-4601 or 1-855-427-5674
Address: Office of Superintendent of Insurance - MHCb
P.O. Box 1689, 1120 Paseo de Peralta Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCb
E-mail: mhcb.grievance@state.nm.us

Who can request a review?

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

Appealing an adverse determination – first level review

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

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

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

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

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

How long does a first level internal review take?

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

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

The medical director denied my request - now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

- If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel members. Your health provider may also address the panel or send a written statement.
- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

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

How long do I have to make my decision?

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

What happens during a panel review?

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

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in

person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement.

The insurer's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you have already received the services. You will be notified within 1 day after the panel decision. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

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

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

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

What's an IRO and what does it do?

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

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

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

How long does an IRO review take?

The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an

expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

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

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

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

Review of an Administrative Decision

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

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

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

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

Can I appeal the decision from the internal reviewer?

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

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

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

review. The committee will meet to review the decision within 15 days after the insurer receives your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

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

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

How can I request an external review?

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

How does the external review work?

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

General Information

Confidentiality

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

Special needs and cultural and linguistic diversity

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

Reporting requirements

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

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

RECORDS

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

Creation of Non-Medical Records

We shall keep your records related to personal identification information, which does not specifically relate to your medical diagnosis or treatment. You shall forward information periodically to us as we may require in connection with the administration of this Agreement.

Accuracy of Information

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

Consent for Use and Disclosure of Medical Records

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

Professional Review

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

Confidentiality of Protected Health Information/Medical Records

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

➤ **What is PHI?**

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

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

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

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

➤ **Access to PHI**

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

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

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

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

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

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

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

➤ **Routine Uses and Disclosures of PHI**

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

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

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

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

➤ **Consents/Authorizations**

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

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

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

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

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


Call PCSC
505-923-5678
1-800-356-2219

To request an Authorization Form, please contact our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678** or toll-free at **1-800-356-2219**. Hearing impaired users may call the **TTY line at 711** or visit our website at www.phs.org. Authorization Forms will be kept in your medical record or enrollment file.

➤ **Members Who Are Unable to Give Consent/Authorization**

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

➤ **Right to Request Amendments (Changes) to PHI**

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

➤ **Process for Members to Request an Accounting of Disclosures of PHI**

You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center by calling Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711** or visit our website at www.phs.org. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you to others without authorization from you.


Call PCSC
505-923-5678
1-800-356-2219

➤ **Restriction of PHI Use or Disclosures:**

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

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

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

➤ **Use of Measurement Data**

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

➤ **Internal Protection of Oral, Written and Electronic PHI Across PHP**

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

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

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

➤ **Website Internet Information**

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

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

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

- Personal information that you provide to us (such as your name, address, billing information, Health Benefit Plan enrollment status, etc.) if you fill out a form on our website

We use your personal information to reply to your concerns. We save this information as needed to keep responsible records and handle inquiries.

We do not sell, trade, or rent personal information provided by visitors to our website to other persons, companies or partners.

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

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



If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678 or toll-free at 1-800-356-2219**. Hearing impaired users may call the **TTY line at 711** or visit our website at www.phs.org.

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATES, TERMINATION AND CONTINUATION

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

How You Can Enroll as a Member

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

Eligible Subscribers

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

- Be an active permanent full-time employee of the Group who is currently working the minimum number of hours specified in the Group Letter of Agreement (GLA) and has completed the required probationary period and the required waiting period.
- Physically live or work (commuting daily) in the State of New Mexico, our Service Area.
- Continue to meet your Group specific enrollment and eligibility requirements as outlined in the GLA.

A Subscriber who has had a prior Contract or Agreement with us terminated for Good Cause, as described in the **Glossary of Terms** section or under any similar Sections of our other Agreements, is not eligible to enroll.

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

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

Eligible Dependents

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

- Your legally married Spouse (of the Subscriber), as defined by state law
- Your Domestic Partner as defined by and if specified as eligible by your Employer Group.
- Your Dependent child who is:
 - under 26 years of age; your natural child, a legally adopted child, or a child for whom you are legal guardian or have legal custody as defined by state law



Refer to



Important
Information



Important
Information

- your stepchild (foster children are not eligible)
- a child of non-custodial parent(s)
- in your custodial care as appointed by court order
- a child for which a court or qualified administrative order is imposed
- you or your Spouse's Dependent child for whom you are required by court order to provide health care Coverage.

We will require proof, such as legal adoption or guardianship papers, income tax forms, court orders or administrative orders that a child qualifies as a Dependent for Coverage under this Agreement.

The enrollment of a Dependent child for Covered Benefits under this Contract shall terminate at the end of the month of the child's 26th birthday unless the Dependent child is totally and permanently disabled.

A Dependent who has had a prior Contract or Agreement with us terminated for Good Cause, as described in the **Glossary of Terms Section** or under any similar Sections of our other Agreements, is not eligible to enroll.

Court Ordered Coverage for Dependent Children in the Service Area

The Dependent who is eligible due to a court order will be allowed to apply. Other siblings of the court-ordered Dependent, who do not meet the eligibility requirements as explained above, will not be eligible for Coverage.

Dependents of Non-Custodial Parents

When a Dependent child has Coverage through a non-custodial parent, we shall:

- Provide such information to the custodial parent as may be necessary for the child to obtain Covered Benefits.
- Permit the custodial parent or the Practitioner/Provider, with the custodial parent's approval, to submit claims for Covered Benefits without the approval of the non-custodial parent.
- Make payment on claims for Covered Benefits submitted by the custodial parent (as explained above) directly to the custodial parent, the Practitioner/Provider or the state Medicaid agency.

Residence of a Dependent Child

Dependent Student

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



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

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

Total and Permanent Disability of an Enrolled Dependent Child

When an enrolled Dependent child reaches his or her **26th birthday** and is totally and permanently disabled, the Coverage of the Dependent under this Agreement will not terminate. The enrolled Dependent must be incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish us with proof of such disability, incapacity and dependence within **31 days** of the Dependent child's attainment of age 26. If we approve continued Coverage, we may request proof of the disability on each birthday thereafter.

Medicare-Eligible Members (TEFRA)

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

➤ If Medicare is Secondary (TEFRA)

If your Group is subject to the Tax Equity & Fiscal Responsibility Act (TEFRA) and if you are actively at work at age 65 and older, you may continue the Coverage provided under this Agreement until you retire. In that case, this Coverage will be primary over Medicare benefits. There may be other circumstances that allow you to retain this Coverage when you are eligible for Medicare. You should contact the Social Security Administration for more information.

➤ If Medicare is Primary

If you are eligible for Medicare and you select Medicare as your primary health plan, the Coverage under this Plan is not available to you.

➤ If your Group is not subject to the federal law (TEFRA) and is not required to offer Group Coverage that you may select to be primary over Medicare when you are actively working at age 65 and beyond the following may apply:

- Active employees and their dependents who are enrolled in conventional coverage may also enroll in our Group health care Plans.
- For Groups with 2-19 total employees, Medicare Parts A&B are considered the Primary insurance carrier and we would be the secondary carrier.



- If your Group does not offer Coverage secondary to Medicare, please refer to “Continuation of Coverage” later in this Section for more Coverage options.

Subscribers and Dependents Who May NOT Enroll

- A Subscriber’s grandchild is not eligible for Coverage unless the grandchild meets the eligibility criteria for a Dependent.
- A child born of a Member, when the Member is acting as a surrogate parent, is not eligible for Coverage.
- A Subscriber and/or Dependent is not eligible to enroll for Coverage if either Subscriber or Dependent has had a prior Contract or Agreement with us terminated for Good Cause as described in the **Glossary of Terms Section** or under any similar Sections of our other Agreements, unless we review and approve the new enrollment, in writing.

Enrollment and Effective Dates

If you meet the Subscriber or Dependent eligibility criteria, you may enroll in our Coverage by submitting a completed Application, together with any required Prepayment, at the appropriate times as discussed below.

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

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

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

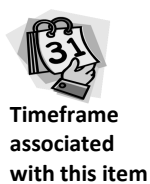
The Annual Group Enrollment Period

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

Newly Hired Employees During the Year

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





the earliest time you and your eligible Dependents may enroll is the next occurring Annual Group Enrollment Period except as specifically described in the **Special Enrollment Section**.

Family Status or Employment Status Changes During the Year

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

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

➤ Marriage

Your newly acquired Spouse (and any children of the Spouse eligible for Coverage under this Section) is eligible to be enrolled as a Dependent. You must complete and sign an Application and submit it, along with any required Prepayment, to your Employer Group within **31 days** from the date of marriage. Coverage will become effective on the first day of the month following the date of marriage.

➤ Divorce or legal separation

You must notify us within **31 days** of the date of divorce or legal separation of the change in Dependent Coverage and submit any Prepayment amount. Coverage will be effective as of the first day of the month following the date we receive the notification.

➤ Birth of a child

Your newborn or the newborn of your Spouse will be Covered from the moment of birth when enrolled as follows:

- We must receive the signed and completed Application that was submitted to the Employer Group within **31 days** from the date of birth.
- If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed Application within the first **31 days** following the date of birth.

If the above two conditions are not met, we will not enroll the newborn for Coverage until the next following Annual Group Enrollment Period. Please refer to the **Benefits Section, Prior Authorization Section, Limitations Section and Exclusions Section** to fully understand the benefits and requirements for Maternity and newborn Coverage.

➤ Adoption of a child

- A child under age 18 who is placed in your home for the purposes of adoption and for whom you have commenced adoption proceedings is eligible to be enrolled as a Dependent.



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

➤ Legal Guardianship



Timeframe
associated
with this item

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

➤ Court ordered or qualified administrative ordered eligible Dependent Coverage



Timeframe
associated
with this item

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



Timeframe
associated
with this item

- If the Subscriber, who is not enrolled in our Coverage, has not met the waiting period and other eligibility requirements, the Subscriber may not enroll and may not enroll the Dependent child until the date that eligibility requirements have been met. The Subscriber must submit the Application and any Prepayment within **31 days** from the eligibility date. The Dependent will become a Member on the date of the Application.

Note: Only the eligible court-ordered Dependent(s) will be allowed to enroll as a result of the court and/or qualified administrative order. Other Dependents who are not enrolled may not enroll at this time.



- The last day of the month in which your Dependent child turns age 26 (when Dependent Coverage will terminate unless the Dependent child is as described in the **Totally and Permanently Disabled Dependent Child in this Section**)
- The death of your Spouse or Dependent child
- Disqualification or requalification of your Dependent

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

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

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

Special Enrollment for Active Employees and their Dependents

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

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

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



**Timeframe
associated
with this item**

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

Special Enrollment - Change in Family Status

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

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

Effective date of the Family Special Enrollment:

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

Special Enrollment - Loss of Coverage

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

- The person was covered under a Group Health Benefits Plan or had individual health insurance coverage at the time the person was initially eligible to enroll.
- At the time, the employee (Subscriber) of the Group was first eligible to enroll, the employee stated, that the employee and/or eligible Dependents were not enrolling because of such other coverage. The employer may require this in writing.
- The person's coverage under the other plan or insurance:
 - Was under a Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 continuation provision and the coverage under that provision was exhausted (and not voluntarily terminated).



Timeframe
associated
with this item

- Was not under a COBRA continuation period and either the coverage was terminated as a result of loss of eligibility or employer contributions toward the coverage were terminated.

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



Timeframe
associated
with this item



Refer to

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

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

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

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

➤ **Loss of Medicaid/CHIP Eligibility**



Timeframe
associated
with this item

- If you, as an eligible Subscriber, chose not to enroll in our Coverage for yourself and/or Dependent(s) during a previous enrollment period because you and/or your Dependent(s) were covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan, the person who loses Medicaid/CHIP eligibility may enroll in our Coverage. If you, as an eligible Subscriber, are not enrolled for Coverage, you must enroll in our Coverage at the same time as your Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of the date Medicaid or CHIP coverage terminated.
- You must submit a completed, signed Application within **60 days** of the loss of Medicaid or CHIP coverage. We will require documentation from the State supporting the fact that the person who had the Medicaid/CHIP Coverage lost the Coverage voluntarily. Coverage will start no later than the first day of the month after we receive your Application and any required Prepayment.
- If you, as Subscriber, lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and your Dependents, including your Spouse. If your Dependent lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and that Dependent (not other Dependents).

Full, Accurate and Complete Information

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

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

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

Change in Address, Family Status and Employment

Changes in your Dependents, marital status, employment or address may affect your Coverage under this Agreement. Please notify your Employer Group's human resources office and ask that they notify us of all changes. You may notify us directly by calling our Presbyterian Customer Service Center at **(505) 923-5678 or toll-free at 1-800-923-2219**, Monday through Friday from 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY line at 711**. Or visit our website at www.phs.org.



Call PCSC
505-923-5678
1-800-923-2219

Termination of Coverage

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

➤ Termination of the Employer Group For Non-payment

- In the event any Contract charge, including a Prepayment and any applicable finance charge or charges, is not paid to us when it is due from the Group, we shall notify and mail a Notice of Cancellation to the Group within 30 days. The Group shall then immediately forward to each Subscriber, by first-class mail at his or her current address, a legible copy of such notice. Termination of this Agreement shall not become effective sooner than 30 days after the date the notice is hand delivered or mailed to each Subscriber.
- If we receive payment of the Contract charge (including any Prepayment and all other applicable amounts and charges) within **15 days** of the issuance of the Notice of Cancellation, it shall be sufficient to prevent cancellation and termination under this paragraph. If we do not receive payment of such charge within this **15-day period**, we may, at our option, either:
 - Require that a new Application for Coverage be submitted, notifying the Group of the conditions under which a new Contract will be issued or the original Application reinstated; or
 - Elect to abide by this cancellation by returning to the Group, within **20 business days** after receipt, any Prepayment for Coverage for periods after the effective date of cancellation.



Timeframe
associated
with this item

- Cancellation and termination of this Agreement under this paragraph shall become effective as of the last date of Prepayment. We shall be entitled to recover from the Group or from the Subscriber any and all payments for Covered Benefits made on behalf of any Subscriber or the Subscriber's Dependent(s) after the last date of the period for which Prepayment was received.

- **Voluntary Termination by the Employer Group of the Group Letter of Agreement (GLA)**

Voluntary Termination of Coverage by the Group is governed by the terms of the GLA. Such termination shall only be effective as of the last day of the month.

- **Our Termination of your Employer Group**

Our termination of the Group is governed by the terms of the GLA and is in accordance with federal and state laws. Our termination or cancellation of the Group shall automatically terminate this Agreement. Upon our cancellation or termination of our Contract with the Group, the Group shall promptly mail a legible copy of the Notice of Cancellation to each Subscriber at the Subscriber's current address and shall promptly provide us with proof of such mailing and the date thereof.

Such cancellation shall become effective no sooner than 30 days after the date the Group mails the notice to Subscribers. The notice requirement in this paragraph does not apply to our refusal to renew any GLA that does not contain an automatic renewal provision.

- **Termination of your Group Subscriber Agreement**

This Agreement shall be cancelled and your (Subscriber and Dependent) Coverage shall terminate in the event any one of the following conditions occurs:

- Your failure to pay required Cost Sharing

On the date we specify, this Agreement will terminate if you refuse to pay any required Cost Sharing (Deductible, Coinsurance and/or Copayment) for Health Care Services rendered, provided that we send written notice to you (the Subscriber) at least **30 days** in advance of such termination. You may not re-enroll until the Group's next Annual Enrollment Period. We will not terminate your Coverage for nonpayment of Cost Sharing amounts during any period in which you are Hospitalized and receiving treatment for a life-threatening condition. In addition, we will not terminate your Coverage for refusal to follow any prescribed course of treatment.

- False Material Information/Rescissions

On the date we specify, this Agreement will terminate if you (the Subscriber) have knowingly given false material information in connection with your eligibility or enrollment of yourself or any of your Dependents, provided we send written notice to you (the Subscriber) at least **30 days** in advance of such termination. In such case we, at our sole discretion, may terminate Coverage for you and all of your Dependents, and may make such termination effective retroactively as of the date of enrollment. You shall be responsible for payment for all Health Care Services rendered hereunder as of the effective date of such termination and shall reimburse us for all such



Health Care Benefit payments that we made on your behalf or on behalf of any of your Dependents.

- **Military Service**
Coverage for you (Subscriber) and your eligible Dependents will terminate at the end of the month during which you entered into active military duty (except for temporary duty of 30 days or less).
- At the end of the Contract month in which you (the Subscriber) cease to physically live within the State of New Mexico or work for an employer headquartered in the State of New Mexico, our Service Area. Coverage for all Dependents will terminate on the same date as your (the Subscriber's) coverage.
- At the end of the Contract month in which you cease to be eligible as a Subscriber or Dependent.
- On the date that adoption placement for the child originally placed for adoption, is disrupted prior to legal adoption, and is removed from placement.
- As of the date on which you permit the use of our Identification Card by any other person, we may, at our discretion, terminate Coverage for you and for all Members of your family. We must send written notice to you (Subscriber) at least **30 days** in advance of such termination.
- If two or more Practitioners/Providers, after a reasonable effort, are unable to establish and maintain a satisfactory Practitioner/Provider-patient relationship with you or any of your Dependents, then the rights of that Member under this Agreement may be terminated provided we send written notice to you (Subscriber) at least **30 days** in advance of such termination.
- If you or any of your Dependents are responsible for a material failure to abide by our rules and/or policies and procedures, then the rights of such Member under this Agreement may be terminated upon the date we specify, provided we send written notice to you (Subscriber) at least **30 days** in advance of such termination.
- If you or any of your Dependents are terminated for Good Cause, as defined in the **Glossary of Terms Section**, then you or any of your Dependents are not eligible for COBRA continuation or Individual Conversion.



We will not terminate Coverage under this Agreement for any Member based solely upon the Member's health status, requirements for Health Care Service, race, gender, age, sexual orientation, or for refusal to follow a prescribed course of treatment. If you or your Covered Dependents believe that Coverage was terminated due to health status or health care requirements, you may Appeal the cancellation to the Superintendent of Insurance, by mail, Attention: External Review Request, Office of Superintendent of Insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689; or by e-mail at mhcb.grievances@state.nm.us; or fax at (505) 827-4734.

Unless we agree, in writing, no Covered Benefits shall be provided under this Agreement following the date this Agreement terminates including, but not limited to, when you or your Covered Dependent remains in the Hospital after the date of termination of this Agreement.

We shall be entitled to recover from you (Subscriber) any and all payments for Covered Benefits made on behalf of you or your Dependents after the last date this Agreement was in force.



Timeframe
associated
with this item

Notice of Termination to Members

If this Agreement is terminated for cause, we will send a Notice of Cancellation to you (the Subscriber) no less than **30 days** prior to the effective date of termination.

- The notice will be dated
- State the reason(s) for termination
- State your right to file a Complaint with the Superintendent of Insurance if you feel you have been wrongly dis-enrolled (had your Coverage terminated)
- Provide information about your ability to enroll in a conversion plan
- Include other matters required by law, including information related to premium refunds, if any, and reinstatement

Continuation of Coverage of your Group Plan

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985

Most Employer Groups with 20 or more employees are required to offer continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

- If you lose eligibility for Coverage and if you are entitled to COBRA Coverage, you may continue your Coverage as a Member of the Employer Group under this Agreement and in accordance with the GLA for the period of time allowed under COBRA unless and until:
 - You terminate your Coverage.
 - Your Coverage under this Agreement is terminated for Good Cause.
 - You fail to make a timely election for COBRA Coverage.
 - You fail to make timely payments for your COBRA Coverage.
 - You become Covered under another Group Health Care Plan.
 - You become entitled to Medicare benefits.
- Your Group's benefit administrator will provide you with information about your eligibility for COBRA. If you are eligible, you (the Subscriber) or your eligible Dependent must elect COBRA Coverage within **60 days** of the date you lose eligibility for Coverage under this Agreement. Your COBRA Coverage will be effective only if we receive your COBRA Application within **60 days** after the date your Group Coverage under this Agreement terminates.



Timeframe
associated
with this item

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

- Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for COBRA continuation.

State Continuation of Group Coverage

Employer groups with fewer than 20 active employees (or otherwise not required to offer COBRA continuation) may provide continuation of non-COBRA Coverage.

- You, on behalf of yourself and your Dependent(s), upon termination of employment with the Employer Group, have the right to continue your Group Coverage for six months under state law. At the end of the six months, you may convert your Coverage to the individual conversion option that we offer, in accordance with the non-Group Coverage Section.

- An enrolled Dependent, upon loss of eligibility for Coverage under this Agreement (following the continuation of Group Coverage for six months under state law), may have the option of converting the Group Coverage to the individual conversion option we offer. The circumstances and conditions under which conversion is allowed are specified in the **non-Group Coverage Section**.

- Coverage under this State Continuation option will terminate prior to the end of the six-month period of Coverage in the event:

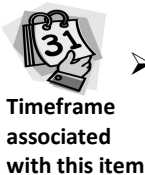
- You terminate your Coverage.
- Your Coverage under this Agreement is terminated for Good Cause.
- You fail to make a timely election for continuation Coverage.
- You fail to make timely payments for your continuation Coverage.
- You become Covered under another Group health plan.
- You become entitled to Medicare benefits.

- State continuation Coverage is effective only if we receive your continuation Application and the applicable Prepayment within **31 days** after the date your Group Coverage under this Agreement terminates.

Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for state continuation Coverage.

Eligibility for Individual Conversion Option

If you are still Covered by Presbyterian Insurance Company, Inc., at the expiration of any continuation period (whether under COBRA or state law), you will have the option of converting your continuation



Coverage to the Individual Conversion Option we provide in accordance with the provisions of the **non-Group Coverage Section**.

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

Conversion to non-Group Coverage (Individual Conversion Option)

You may be eligible to enroll in non-Group coverage as follows:

- You (on behalf of yourself and your enrolled Dependents) shall have the right to convert to a non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon exhausting the benefits of the your COBRA or state continuation coverage.
- An enrolled Dependent Member under this Agreement shall have the right to convert to a separate, non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon termination of the Dependent's benefit period under COBRA or state continuation, if any.

When your (Subscriber) Dependent Spouse elects Conversion coverage, the Dependent Spouse may include coverage for Dependent children for whom the Dependent Spouse has responsibility for care and support.

At the time of Conversion, the Individual Conversion or non-Group coverage provided shall consist of a form of coverage that we are then issuing as an Individual Conversion Contract. However, at the time of Conversion, if you or your eligible Dependent are eligible for Medicare, the right to convert may be limited to coverage under a Medicare Supplemental Insurance Contract.



Timeframe
associated
with this item

Individual Conversion Coverage is effective only if we receive your Individual Conversion Application and the applicable Prepayment within **31 days** after the date your Group Coverage under this Agreement terminates.

Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for the Individual Conversion Option.

You, as the Subscriber, may terminate Individual non-Group Membership Coverage with no less than **30 days** written notice.

Extension of Benefits for the Totally Disabled

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

For purposes of this section, totally disabled means that an individual is prevented, solely because injury or disease, from performing their regular or customary occupational duties or is incapable of doing most of the normal activities and tasks for that person's age and family status. In order to qualify for benefits under this extension, you must have been totally disabled on the date that the Group Coverage terminates, incur an expense directly resulting from that particular disability and such expense would have been a Covered Benefit before termination.



Refer to



Timeframe
associated
with this item

GENERAL PROVISIONS

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

Amendments (Group)

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

Assignment

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

Availability of Provider Services

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

Entire Contract

This Agreement, the *Summary of Benefits and Coverage*, any amendments, Endorsements, supplements or riders, the GLA or the non-Group Membership Letter of Agreement, the Employee Action Form and/or Universal/Uniform Medical Assessment Form (Application) completed upon enrollment (if applicable) by the Subscriber Covered hereunder and our issued Identification Card constitute the entire Contract between the parties and, as of the effective date hereof, supersede all other agreements between the parties.

Execution of Contract - Application for Coverage

The parties acknowledge and agree that your signature or execution of the Application shall be deemed to be your acceptance of the Contract, including the GLA and this Agreement. All statements, in the absence of fraud, made by any applicant (you and/or your Dependents) shall be deemed representations and not warranties. No such statements shall void Coverage or reduce benefits unless contained in a written Employee Action Form and/or Uniform Medical Assessment Form, which is an Application for Coverage.

Federal and State Health Care Reform

We shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects our obligations under this Agreement, this Agreement will be deemed automatically amended such that we shall remain in compliance with the obligations imposed by such law, rule or regulation.

Fraud

We are required to cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Practitioner/Provider activity and Member activity.

Practitioner/Provider Activity

If you suspect that a Practitioner, pharmacy, Hospital, facility or other Health Care Professional has done any of the items listed below, please call the Practitioner or Provider and ask for an explanation. There may be an error.

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

If you are unable to resolve the issue, or if you suspect any other suspicious activity, please contact our Special Investigative Unit (SIU) hotline at **(505) 923-5959** or toll-free within New Mexico at **1-800-239-3147**.

This confidential voicemail box is available 24 hours a day. Any information you provide will be treated with strict confidentiality. When reporting suspected health insurance fraud, you may remain anonymous. You can also contact the SIU via email at PHPFraud@phs.org or by mail at:

Presbyterian Health Plan
Special Investigative Unit (SIU)
P.O. Box 27489
Albuquerque, NM 87125-7489

Member Activity

Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate enrollment for any Member for any type of fraudulent activity. Some examples of fraudulent activity are:

- Falsifying enrollment information
- Allowing someone else to use your ID Card
- Forging or selling prescriptions
- Misrepresenting a medical condition in order to receive Covered Benefits to which you would not normally be entitled

Governing Law

This Agreement is made and shall be interpreted under the laws of the State of New Mexico and applicable federal rules and regulations.

Identification Cards

We issue Identification (ID) Cards to you, pursuant to the GLA, for identification purposes only. Possession of our ID Card confers no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the ID Card must, in fact, be a Member on whose behalf all applicable Contract charges have actually been paid. If you or any family Member permits the use of your ID Card by any other person, all your rights and other Members of your family pursuant to this Agreement may be immediately terminated at our discretion. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Contract shall be charged therefore at the rates generally charged in the area for medical, Hospital and other Health Care Services.

Legal Actions

No action at law or in equity shall be brought to recover on this Agreement by the Group or a Member prior to the expiration of 60 days after written proof of loss has been furnished, in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Misrepresentation of Information

If, in the first two (2) years from the effective date of your and/or your Dependents Coverage, we determine that you intentionally omitted information from your Employee Action Form, the Universal/Uniform Medical Assessment form or other Coverage Application and/or you provided fraudulent or false information, the Coverage for you and/or your Dependent shall be null and void from the effective date. In the case of fraud, no time limits shall apply and you will be required to pay for all benefits that we have provided.

Misstatements

No misstatements, except fraudulent misstatements, made by the applicant in the Employee Action Form, the Universal/Uniform Medical Assessment Form or other Application for Coverage for this Contract shall be used to void the Contract or to deny a claim for loss incurred or disability (as defined in this Group Subscriber Agreement).

Notice

If we are required or permitted by this Agreement to give any Notice to the Group, Subscriber or Member, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to the Group, Subscriber or Member at the address of record on file at our principal office. The Group is solely responsible for ensuring the accuracy of its addresses and the Subscriber and/or Member is solely responsible for ensuring the accuracy of his/her address of record on file with us.

Policies and Procedures

We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

Reinstatements

We may reinstate this Agreement after termination without the execution of a new Application or the issuance of a new Identification Card or any notice to the Subscriber or Member, other than the unqualified acceptance of an additional payment from the Group or Remitting Agent.

Right to Examine

We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Waiver by Agents

No agent or other person, except an officer of Presbyterian Health Plan has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making payment, or to bind Presbyterian Health Plan by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an Endorsement or amendment in writing to this Agreement or the applicable GLA or non-Group Membership Letter of Agreement signed by one of the aforesaid officers.

Workers' Compensation Insurance

This Agreement is not in lieu of and does not affect any requirement for Coverage by the New Mexico Workers Compensation Act. However, an employee of a professional or business corporation may affirmatively elect not to accept the provisions of the New Mexico Workers Compensation Act.

GLOSSARY OF TERMS

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

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

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

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

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

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

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

Agreement means this Group Subscriber Agreement, including supplements, Endorsements or riders, if any.

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

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

Annual Group Enrollment Period means a period of at least 10 working days prior to the expiration of each Contract Year mutually agreed to by our company and the Group, during which

eligible Subscribers are given the opportunity to enroll themselves and their eligible Dependents under the Agreement without providing satisfactory evidence of good health.

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

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

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

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

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

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

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

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

Calendar Year means the period beginning January 1 and ending December 31 of the same year.

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

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

Certificate of Creditable Coverage means a Certificate given to a Member when his/her enrollment from our Coverage terminates and which states the period of time that we Covered the Member under a benefit plan for Health Care Services. Either we or the Member's Employer may be responsible to prepare and deliver the Certificate, in compliance with all applicable requirements of state and federal law, to the Member.

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

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

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

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

Coinsurance is part of the payment that a Member must pay toward Health Care Services, also known as Cost Sharing. It means the amount of Covered charges calculated as a percentage, after any Deductible and Copayments have been paid, that a Member must pay directly to the Practitioner/Provider in connection with Covered Health Care Services.

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

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

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

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

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

Copayment is part of the contribution that Members make toward the cost of their Health Care Services also known as Cost Sharing. It means the fixed amount that the Member must pay directly to the Practitioner/Provider in connection with Covered Health Care Services. The fixed amount may vary by the type of Covered Health Care Service provided.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

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

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

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

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

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

Culturally and Linguistically appropriate manner of notice means:

- The notice that meets the following requirements:
 - The Health Care Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language.
 - The Health Care Insurer must provide, upon request, a notice in any applicable non-English language.
 - The Health Care Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Health Care Insurer.
- For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the Department of Health and Human services (HHS). The counties that meet this ten percent (10%) standard, as determined by HHS, are found at <http://cciio.cms.gov/resources/factsheets/clas-data.html> and any necessary changes to this list are posted by HHS annually.

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

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

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

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

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

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

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

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

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

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

- Disfigurement to the person

Emergency Medical Condition means an illness, injury, symptom or condition that is so serious that a Reasonable/Prudent Layperson, who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Health Care Services would seek care right away to avoid severe harm. Refer to **Reasonable/Prudent Layperson** definition in this Glossary.

Endorsement means a provision added to the Group Subscriber Agreement that changes its original intent.

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

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

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

Experimental or Investigational medical, surgical, other health care procedures or treatments, including drugs. As used in this Agreement, “Experimental” or “Investigational” as related to drugs, devices, medical treatments or procedures means:

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

- As used in this section, “Experimental” or “Investigational” does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

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

Family, Infant and Toddler (FIT) Program means an early intervention services program provided by the Healthy Family and Children’s Health Care Services to eligible children and their families.

FDA means the United States Food and Drug Administration.

Formulary means a list of drugs approved for Coverage and the tier level at which each is Covered under this Agreement. Our Pharmacy and Therapeutics Committee continually updates this listing. A copy of this listing is available on our website at www.phs.org or by calling our Presbyterian’s Customer Service Center at **(505) 923-5678 or toll-free at 1-800-356-2219**, Monday through Friday, 7:00 a.m. to 6:00 p.m. Hearing impaired users may call our **TTY line at 711**.

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

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

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

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

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

Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person’s authorized representative or Practitioner/Provider, acting on behalf of that person with that person’s consent, entitled to receive health care benefits provided by the health care plan.

- An individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan.
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

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

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

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

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

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

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

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

Health Care Professional means a physician or other health care Practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law. See **Practitioner**.

Health Care Services means services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the Health Benefits Plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

Health Maintenance Organization (HMO) means any person who undertakes to provide or arrange for the delivery of basic Health Care Services to Covered Persons on a prepaid basis, except for Cover Person responsibility for Cost Sharing (Deductibles, Coinsurance and/or Copayments).

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

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

Home Health Agency means a facility or program, which is licensed, certified or otherwise authorized pursuant to state laws as a Home Health Agency.

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

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

Hospital means an acute care general Hospital, which:

- Provides Inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed Practitioners/Providers.
- Is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.
- Is duly licensed to operate as an acute care general Hospital under applicable state or local law.

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

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

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

- Preventing transplant rejection
- Supplementing chemotherapy
- Treating certain diseases of the immune system (i.e. "autoimmune" diseases)
- Reducing inflammation
- Relieving certain symptoms

- Other times when it may be helpful to suppress the human immune response

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

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

In-network Physician means any duly licensed Practitioner of the healing arts acting within the scope of his or her license who has entered into an agreement directly with us to provide Health Care Services to our Members.

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

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

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

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

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

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services
- Contracts with selected health care Practitioner/Providers
- Financial incentives or disincentives for Covered Persons to use specific Practitioners/Providers, services, prescription drugs, or service sites
- Controlled access to and coordination of services by a case manager

- Insurer efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care

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

Maternity means Coverage for prenatal, intrapartum, perinatal or postpartum care.

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

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

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

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

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-pocket Maximum means the most that a Member will pay, in total Cost Sharing, during the Calendar or Contract Year. Once a Member has reached the Annual Out-of-pocket Maximum limit, we will pay 100% of the Medicare allowable up to any Lifetime Maximum Benefit limit. The Annual Out-of-pocket Maximum includes Deductible, Coinsurance and Copayments. **It does not include** non-covered charges including charges incurred after the benefit maximum has been reached. Covered charges for In-network Practitioner/Provider services do not apply to the Out-of-network Practitioner/Provider Annual Out-of-pocket Maximum, and Covered charges for Out-of-network Practitioner/Provider services do not apply to the In-network Practitioner/Provider Annual Out-of-pocket Maximum.

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

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

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

PPACA means Patient Protection And Affordable Care Act.

Physician means any dully licensed Practitioner of the healing arts acting within the scope of his/her license.

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

Practitioner/Provider means any duly licensed Practitioner of the healing arts acting within the scope of his/her license.

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

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

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

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

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

Primary Care Physician or Practitioner (PCP) means a Health Care Professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to Members, who may initiate their referral for specialist care, and who maintains continuity of patient care. Primary Care Physicians include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians / Gynecologists (if applicable), Practitioner/Provider Assistants and Nurse Practitioners. Other Health Care Professionals may also provide primary care as necessitated by a Member's health care needs. A list of

Practitioners/Providers who serve as In-network Primary Care Physicians may be found online in the PHP Provider Directory at <https://www.phs.org/Pages/find-a-doctor.aspx>.

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

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

Prospective Enrollee means an individual eligible for enrollment in a MHCP through that individual's group.

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

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

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

Reasonable/Prudent Layperson means a person who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Health Care Services. A Reasonable/Prudent Layperson is considered to have acted "reasonably" if someone else in their same situation would also have believed that emergency care was necessary. Acting "reasonably" could include deciding that severe pain and other symptoms require emergency health care. In determining whether the Member acted as a Reasonable/Prudent Layperson we will consider the following factors:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment
- The presenting symptoms
- Any circumstance that prevented the Member from using our established procedures for obtaining Emergency Health Care Services

Reconstructive Surgery means the following:

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

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

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

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

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

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

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

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

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

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

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

Significant Improvement means that:

- The patient is likely to meet all therapy goals for a reasonable number of visits of therapy or
- The patient has met all therapy goals in the preceding visits of therapy, as specifically documented in the therapy record.

Skilled Nursing Facility means an institution that is licensed under state law to provide skilled care nursing care services and has entered into an agreement with PHP to provide Covered Services to our Members.

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

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

Special Medical Foods means nutritional substances in any form that are used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require Prior Authorization through Presbyterian's Pharmacy Department.

Specialty Pharmaceuticals Tier 4: Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or care-giver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life threatening conditions. Most Specialty Pharmaceuticals require **Prior Authorization** and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than \$600 for a 30 day supply. **Specialty Pharmaceuticals** are not available through the mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill up to a 14-day supply to ensure patients can tolerate the new medication. For a complete list of these drugs, please see the **formulary list** at www.phs.org. The medications listed on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan. You can call our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at **(505) 923-5678, toll-free 1-800-356-2219**. Hearing impaired users may call our **TTY line at 711**.

Specialty Pharmacy – Presbyterian's In-network Pharmacy vendor that, under contract or other arrangement with us, provides Covered Specialty Pharmaceuticals to Members.

Spouse - Legally married husband or wife.

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

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

Substance Use Disorder means dependence on or abuse of substances meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

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

Superintendent means The Superintendent of Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

This Group Subscriber Agreement is issued to the Group for the Subscriber named in an Application received and accepted by Presbyterian Health Plan, a New Mexico corporation. The terms and conditions appearing herein and any applicable amendments are part of this Group Subscriber Agreement.

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

PRESBYTERIAN HEALTH PLAN

A handwritten signature in cursive script that reads "Jana Burdick". The ink is dark and the signature is fluid.

[Jana Burdick
Vice President, Chief Service Officer]
Presbyterian Health Plan, Inc.

EXHIBIT A

Statement of ERISA Rights

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

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

Article I. Receive Information about your Plan and Plan Benefits

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

Section 1.01 Continue Group Health Plan Coverage

- Continue health care Coverage for yourself, Spouse or Dependents if there is a loss of Coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such Coverage.
- Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of Coverage for Pre-Existing Conditions under your Group health plan, if you have Creditable Coverage from another plan.

- You should be provided a Certificate of Creditable Coverage, free of charge, from your Group health plan or health insurance issuer when you lose Coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing Coverage, or if you request it up to 24 months after losing Coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months after your enrollment date in your Coverage.

Article II. Prudent Actions by Plan Fiduciaries

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

Section 2.01 Enforce Your Rights

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

Section 2.02 Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the U.S. Department of Labor, Employer Benefit Security Administration at **1-866-444-3272.F**

Trying to quit? You can do it!

Ready to try something new? You may have tried to quit in the past without success. Clickotine will give you the boost you need to quit—and quit for good.

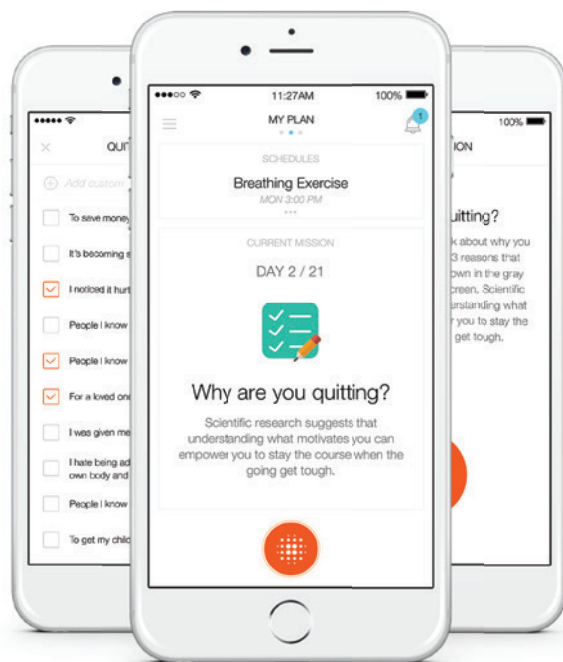
The challenging road to quitting

If you've been smoking for some time, you know how hard it can be to quit. In fact, nearly 70 percent of adult smokers want to stop. People trying to quit often feel alone in their daily struggle. The good news is that it's never too late to work on quitting, and once you do, your health will improve quickly and significantly.

Introducing the Clickotine mobile application

Clickotine is an innovative program that uses clinically-driven app technology to help you create and stick to a quit plan and overcome nicotine cravings. Based on clinical trials and data, Clickotine has a high success rate and includes these key features:

- ✓ **Personalized messaging:** Receive personal messages that keep you on track toward your quit goal.
- ✓ **Controlled breathing:** Monitor and control your breathing—an effective way to reduce nicotine withdrawal symptoms.
- ✓ **Real-time social support:** Post comments and share encouragement with others trying to quit.
- ✓ **Replacement distractions:** Get help diverting cravings to healthier actions.
- ✓ **Money saved:** Track how much money you've saved since your quit date—a powerful motivator for quitting.
- ✓ **Health recovered:** See how quitting has improved your health. As soon as you quit smoking, your body begins to recover.
- ✓ **Journaling:** Document how you're feeling during your quit journey. Not only can it help to relieve stress, it can also help you understand your smoking triggers, when you track your thoughts and feelings during your quit effort.



For more information on how to sign up, contact Customer Service at (505) 923-7787 or 1-855-261-7737 after July 1.

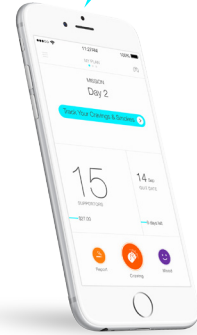


Clickotine®

A Digital Therapeutics™ Program for Smoking Cessation

Finally, Personalized Help to Quit Smoking

It is easy as 1-2-3 to start today!



Visit www.clickotine.com for details.

For more information on how to sign up, contact customer service at (505) 923-7787 or 1-855-261-7737 after July 1.

Partner Dashboard

Providing a web-based portal for partners enables observation of population trends, as well as detailed user-by-user data streams



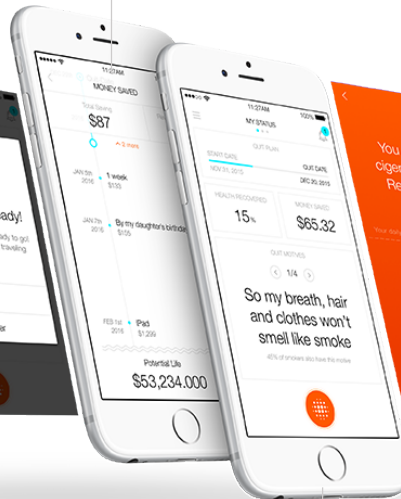
Social Engagement

Real-life support from friends, family and community. Quitting with a small quit team is proven to be a powerful tool or engagement



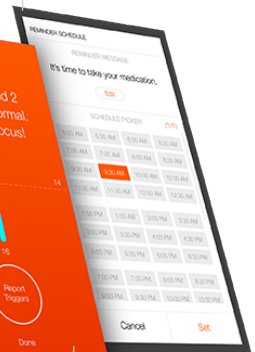
Financial Incentives

Out-of-app incentives such as refunds & reimbursements provided by partners



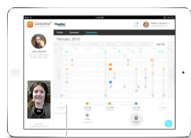
Medication Adherence

Individualized reminder system to optimize use of effective treatment



Professional Caregiving

Real-time access to qualified professional caregivers, quit coaches & counselors



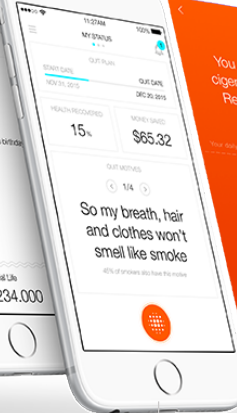
Controlled Breathing

Controlled, mindful breathing experiences coupled with multi-sensory stimuli



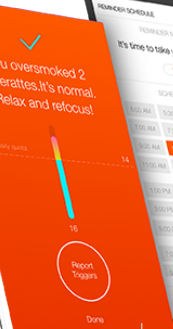
Personalized Messaging

Adaptive text messages tailored to user profile, and provides contextualized, personalized support and guidance



Digital Diversions

Timed and targeted strategies to cope with cravings, withdrawal symptoms & lapses



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SERFF PBHP-131542927



Introducing a new benefit at no cost to you!



Learning how to cope with stress at work and at home can improve your overall well-being and help lower your healthcare costs.

You and family members living in your household can get up to three employee assistance visits per issue through The Solutions Group, a division of Presbyterian Healthcare Services.

Employee Assistance Program (EAP) services are short-term, confidential counseling sessions conducted by local licensed providers and can include:

- mediation services
- substance abuse assessments and referrals
- 24-hour emergency services
- support for supervisors and managers
- optional counseling via Video Visits
- referrals as needed

When faced with complex personal challenges, let our EAP providers help. To schedule an appointment with an EAP counselor, please call 1-866-254-3555 or (505) 254-3555.

Services provided by:



Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

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

If you need these services, contact the Presbyterian Customer Service Center at 505- 923-5420, 1-855-592-7737, TTY: 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, the Privacy Officer and Civil Rights Coordinator is available to help you.

Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125

Phone: 1-866-977-3021, TTY: 711
Fax: 505-923-5124
Email: info@phs.org

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

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

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Aviso de no discriminación y accesibilidad

La discriminación es contra la ley

Presbyterian Health Services (Presbyterian) cumple con todas las leyes de derechos civiles federales aplicables y no discrimina sobre la base de la raza, color, nacionalidad, edad, discapacidad o sexo.

Presbyterian no excluye a las personas ni las trata de manera diferente en base a la raza, color, nacionalidad, edad, discapacidad o sexo.

Presbyterian:

- brinda ayudas y servicios gratuitos a personas con discapacidades para que se comuniquen efectivamente con nosotros, como intérpretes calificados de lenguaje de señas e información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- brinda servicios de idioma gratuito a personas cuyo idioma principal no es el inglés, como intérpretes calificados e información escrita en otros idiomas

Si necesita estos servicios, comuníquese con el Centro de servicio al miembro de Presbyterian llamando al 505-923-5420, 1-855-592-7737, TTY: 711.

Si cree que Presbyterian no le ha brindado estos servicios o lo ha discriminado en otra manera en base a la raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja llamando al Oficial de privacidad de Presbyterian y Coordinadora de derechos civiles, P.O. Box 27489, Albuquerque, NM, 87125, o llame al 1-866-977-3021, TTY: 711, fax 505-923-5124 o info@phs.org. Puede presentar una queja en persona o por correo, correo electrónico, o a los números de teléfono anteriores. Si necesita ayuda para presentar una queja, llame al 1-866-977-3021 y un representante del cliente le ayudará.

También puede presentar una queja a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE.UU. electrónicamente a través del portal de quejas de la Oficina de Derechos Civiles en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o teléfono a:

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

Línea telefónica gratis: 1-800-368-1019, 1-800-537-7697 (TDD)

Los formularios de quejas están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíłnih 505-923-5420, 1-855-592-7737 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420, 1-855-592-7737 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: 505-923-5420, 1-855-592-7737 رقم هاتف الصم والبكم (TTY: 711).
Korean	주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오.
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420、1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).