PRESBYTERIAN

Presbyterian Health Plan, Inc.

Summary Plan Description
and
Guide to Your Preferred Exclusive Provider Organization (EPO) Plan

Albuquerque Public Schools

Offered by the Albuquerque Public Schools
Administered by Presbyterian Health Plan, Inc.

APS
EPO Plans
MPC072146

1/1/2021

WELCOME

This *Summary Plan Description* describes the medical benefits offered to eligible employees of Albuquerque Public Schools (APS).

The Albuquerque Public Schools medical plans are self-insured, in other words, our premium dollars go directly toward the payment of our health care claims. An administration fee is paid to Presbyterian Health Plan to serve as the Claims Administrator for the plan. The administration fee pays for claims processing and payment, customer service, Provider networking, ID Cards, booklets, and some wellness programs.

The APS medical plan offers FREE in-network preventive care. Please take advantage of this benefit after you enroll. Early diagnosis plays a big part in the eventual outcome of any health condition.

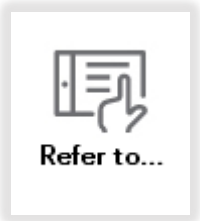
This booklet is intended to provide you with an easy-to-understand explanation of the Plan effective January 1, 2021. Every effort has been made to make these explanations as accurate as possible. In order to have a complete view of your medical plan benefits as an APS employee, in addition to this *Summary Plan Description*, you need to obtain a copy of the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide. These documents are available on the APS website at **http://www.aps.edu/human-resources/benefits** or from the APS Employee Benefits Department. If any conflict should arise between this booklet and the claims administrative procedures of our Claims Administrator, Presbyterian Health Plan, Inc., or if any provision is not covered or only partially covered in this booklet, the terms of the Professional Services Agreement between Albuquerque Public Schools and Presbyterian Health Plan, Inc., and the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide will govern in all cases.

This booklet does not imply a contract of employment. The Albuquerque Public Schools reserves the right to terminate, modify, or change this Plan or any provision of this Plan at any time.

It is your responsibility to read and understand the terms and conditions in this booklet. We urge you to read it carefully and use it to make well-informed benefit decisions for you and your family. If you have questions after you have read this *Summary Plan Description*, please call the Presbyterian Customer Service Center at **(505) 923-5600** (in Albuquerque), or toll-free at **1-888-275-7737**. TTY users may call **711**. You may also contact the APS Employee Benefits Department if you have general questions.

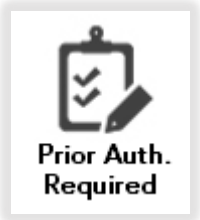
Understanding This Summary Plan Description

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



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

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



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

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

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

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

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

INTRODUCTION

Albuquerque Public Schools (APS) provides group healthcare coverage through the Exclusive Provider Organization (EPO) Medical Plan (Plan) administered by Presbyterian Health Plan, Inc.

You may select an In-network Primary Care Provider (PCP) to direct your health care needs. Your selection must be stated on your enrollment Application. While not required, it is highly recommended that you select an In-network PCP. Please refer to the PHP Provider Directory or the Presbyterian website at www.phs.org when selecting your In-network PCP.

If you obtain services from an In-network Provider/Practitioner, you will not have to file any claims. In-network Providers, are responsible for filing all claims to PHP.

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

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

- Providers are Hospitals and other healthcare Professionals or facilities that provide Healthcare Services.
- In-network PCP's and In-network Providers have contractual agreements with Presbyterian Health Plan, Inc., that allow lower out-of-pocket expenses and additional benefits for covered persons.

Please take the time to read this booklet carefully before placing it in a safe place for future reference. If you have any questions regarding this booklet, please call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. and 6 p.m. at **(505) 923-5600**, or **1-888-275-7737-**. **TTY** users may call **711**. It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

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SUMMARY OF BENEFITS

2021 APS EPO

Administrative Services for the Albuquerque Public Schools self-funded medical plan are provided by Presbyterian Health Plan.		In-network	Out-of-Network
Deductible	Annual Member Deductible (calendar year) Single	$500	
	Two-Party	$1,000	
	Family	$1,250	
	• The deductible does not apply to Preventive Care Services or Prescription Drugs. • Copayments do not apply towards deductible. • Except for Preventive Care and those services where a copayment applies, the deductible must be met before benefit payment is made by the plan (coinsurance applies). • After each family member meets his or her individual plan deductible, the plan will pay a percentage of his or her claims and the member will pay applicable coinsurance until the out-of-pocket maximum is met. • After the family plan deductible has been met, the plan will pay a percentage of each individual's claims and the member(s) will pay applicable coinsurance until the out-of-pocket maximum is met.		
Coinsurance		You pay 20% and the Plan pays 80% after the annual deductible is met	
Out-of-Pocket Maximum	Annual Out-of-Pocket Maximum Single	$4,000	
	Two-Party	$8,000	
	Family	$12,000	
	• The medical plan copayments, deductible and coinsurance apply to the annual out-of-pocket maximum. Prescription drug copayments or coinsurance does not apply to the medical plan out-of-pocket maximum. The prescription drug plan includes a separate out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of that individual's covered expenses. • After the family out-of-pocket maximum has been met, the plan will pay 100% of each family member's covered expenses.		
Provider Services	Non-Specialist • Primary Care Provider (PCP) selection not required	$20 office visit copay	
	Specialist • Referral not required	$50 office visit copay	
	Surgery in Office	Included in office visit copay	
	Injectable drugs administered in provider's office	Copay based on place of service	
	Self-injectable drugs (specialty pharmaceuticals) can be ordered through the prescription drug plan	Refer to the prescription drug plan	

Preventive Care Services[1]	• Routine Provider • Annual women's exam • Annual men's exam including PSA • Related laboratory tests including x-rays (includes routine pap tests, cholesterol tests, urinalysis, mammogram, colonoscopy, etc.) • Well childcare including vision and hearing screenings (through age 21) • Immunizations • Health education and counseling (including smoking/tobacco cessation education) • Family planning	Plan pays 100%	Plan pays 100%
Women's Health Care	Contraceptive methods[1] (preferred agents) • Intrauterine devices (IUD) • Hormone contraceptive injections • Inserted contraceptive devices • Implanted contraceptive devices • Generic birth control Breast feeding support[6] • Supplies and counseling for one year after delivery	Plan pays 100% (prescription medications are covered under the prescription drug plan)	
Outpatient Diagnostic Testing	Advanced Radiology[2] (i.e., PET, MRI, CT scans) • Medically necessary outpatient imaging tests	$120 copay/day (free-standing facility), or 20% coinsurance after deductible: (outpatient department of hospital)	
	Other Laboratory	$20 copay/day	
	Other X-Rays	$20 copay/day	
Hospital Services	Hospitalization[2] • Includes room and board, inpatient provider care - provider visits, surgeon, anesthesiologist, laboratory tests and X-Rays	20% coinsurance after deductible	
	Inpatient Rehabilitation Services[2]	20% coinsurance after deductible	
	Observation Stay[2]	20% coinsurance after deductible	
Sleep Studies	Inpatient[2] Sleep labs (two nights)[2]	20% coinsurance after deductible	
Surgical Services	Inpatient Surgery[2]	20% coinsurance after deductible	
	Outpatient Surgery[2]	20% coinsurance after deductible	
	Office Surgery	Included in office visit copay	
Urgent Care Services	Urgent Care Facility	$50 copay --- Subject to place of service copay or coinsurance	
	Non-urgent follow-up care		
Emergency Services	Emergency Room[4]/Emergency observation treatment[4] • Hospital and Provider charges	$350 copay per visit	
	Non-emergent follow-up care	Subject to place of service copay or deductible and coinsurance	
Ambulance	Ambulance - Emergency and Emergency Air Transport	20% coinsurance after deductible	
Maternity Services	Provider/Midwife Services • Delivery, prenatal and postnatal care	$50 copay –initial visit only, then plan pays 100%	
	Genetic Testing and Counseling	Copay based on place of service	
	Hospital Admission[2]	20 % coinsurance after deductible (on the mother)	

	Routine nursery care for newborn • If mother is covered under the plan • Baby is covered from birth but must be enrolled in the medical plan as quickly as possible but no later than 60 days from date of birth	Plan pays 100%	
	Extended stay charges for covered newborn • If baby is admitted to the hospital post-delivery	20% coinsurance after deductible (on the baby)	
Behavioral/ Health	Outpatient Services	$10 office visit copay up to $260 annual maximum then plan pays 100%	
	Inpatient Services[2] Partial Hospitalization[2] • Two partial hospitalizations equal one inpatient stay Residential Treatment Center[2,3] maximum of 60 days per calendar year	20% coinsurance after deductible 20% coinsurance after deductible	
Alcoholism and/or Substance Use Disorder	Outpatient Services	$10 office visit copay up to $260 annual maximum then plan pays 100%	
	Inpatient Services[2]	20% coinsurance after deductible	
	Partial Hospitalization • Two partial hospitalizations equal one inpatient stay	20% coinsurance after deductible	
	Residential Treatment Center [2,3] • maximum of 60 days per calendar year	20% coinsurance after deductible	
Other Services	Allergy Testing and Treatment	$40 office visit copay	
	Allergy Injections only	Plan pays 100%	
	Allergy Extract preparation	Plan pays 100%	
	Alternative Therapy[3] • Acupuncture, Chiropractic, Massage Therapy and Rolfing maximum of 25 visits per calendar year)	$40 copay per visit	
	Autism Spectrum Disorders[2]	20% coinsurance after deductible	
	• Diagnosis and treatment of autism spectrum disorder for members 19 years of age or younger • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder • The habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Providers must be credentialed to provide such therapy. • Treatment must be prescribed by the member's treating provider in accordance with a treatment plan, and must be preauthorized by Presbyterian Health Plan		
	Biofeedback • For specified medical conditions only	$50 copay per visit	
	Cardiac Rehabilitation[2]	$0 copay per session	
	Pulmonary Rehabilitation[2]	$0 copay per session	
	Chemotherapy and/or Radiation Therapy	20% coinsurance after deductible	
	Dialysis	20% coinsurance after deductible	

Other Services (continued)	Diabetes Coverage • Office visit diabetes education	$10 copay/visit up to $260 annual maximum then plan pays 100%	
	• Diabetes medication	Refer to the prescription drug plan	
	Diabetic supplies, equipment, appliances and services[2] • Prescribed by the attending provider • Purchased through a Durable Medical Equipment (DME) provider	Plan pays 100%	
	Durable Medical Equipment (DME), orthopedic appliances, prosthetics, and functional orthotics[2] • Medically necessary services, supplies and devices • Supplies limited to a 30-day supply during a 30-day period • Rental benefits may not exceed the purchase of a new unit • Support hose limited to 6 pair (or 12 hoses) per calendar year • Mastectomy bras limited to 3 per calendar year	20% coinsurance (deductible does NOT apply)	
	Hearing Aids (Coverage is limited to dependents under age 21 only)	The plan pays 100% of the covered charges (including fitting and dispensing services) up to a maximum of $2,200 every 36 months per hearing impaired hear	
	Home Health Care[2]/Home Intravenous Service[2] Prescribed home provider services, nursing care and rehabilitative therapy	$50 copay per visit	
	Hospice	20% coinsurance after deductible	
	Bereavement Counseling[3] (Limited to 3 sessions during the hospice benefit period)	20% coinsurance after deductible	
	Respite Care[3] (Limited to 5 continuous days for each 60 days of hospice care. No more than two respite stays allowed.)	20% coinsurance after deductible	
	Infertility related services • Test performed in a laboratory • Test performed in a Non-Specialist Provider's office • (Refer to the Summary Plan Description for covered services)	Copays based on place of service	
	Physical, Occupational, and Speech Therapy[3] (maximum of 60 visits per condition per calendar year)	$15 copay per visit up to a maximum of $240 per calendar year	
	Skilled Nursing Facility[3] (maximum of 60 days per condition per calendar year)	20% coinsurance after deductible	
	Tobacco Cessation[3]	Plan pays 100%	
	• Screening for tobacco use • At least two tobacco cessation attempts per year which include: • Four tobacco cessation counseling sessions of at least 10 minutes each (telephone counseling, group counseling or individual counseling) • No prior authorization required Tobacco cessation medications prescribed by a healthcare provider are covered under the prescription drug plan		
	Dental Services[2] (For limited medical conditions only)	20% coinsurance after deductible	
Pre-Existing Conditions	Pre-Existing Condition Limitations	Not Applicable	

Transplants	Coverage for human organ transplants[5] • Case Management required • Refer to Summary Plan Description for complete details on transplant coverage • Maximums apply to covered travel and lodging services	20% coinsurance after deductible	
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at 1-866-563-9297		

1. The Patient Protection and Affordable Care Act (also known as Health Care Reform) requires health plans to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to the member when the services are provided by an In-Network Participating Provider. Although these services are covered at no charge, the provider may charge a copayment for other services provided during the office visit. Additionally, some covered Family Planning services, including male vasectomies, continue to require member cost-sharing. If you have questions regarding the Preventive Care Services that are covered under this plan, including Family Planning Services, or your cost for these services, please refer to your Evidence of Coverage/ Summary Plan Description, or contact Presbyterian Health Plan at the phone number listed on your ID card. These services must be Medically Necessary as defined by the Summary Plan Description.

2. Pre-Admission Review and/or Prior Authorization is required; $300 penalty, reduction or denial may apply to facility and provider services if the required Pre-Admission Review and/or Prior Authorization is not obtained.

3. This benefit includes an annual visit limitation. See your Summary Plan Description for more information.

4. The Emergency Services copayment/deductible/coinsurance is waived if an inpatient hospital admission results; then the hospital admission deductible and coinsurance applies.

5. Transplants are covered In-Network only by Tier I or Tier II providers. Case Management Services for transplant patients ***must*** be obtained from Presbyterian Health Plan at the phone number listed on your ID card.

6. Patients are responsible for copayments or deductible and coinsurance related to place of service, ancillary services, and additional procedures performed at the same time. Prior Authorization rules still apply.

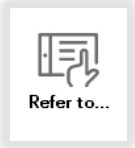
7. If you choose to receive routine care from Tier III providers, payments by the plan for Covered Services will be limited to Medicare Allowable Amounts. For care other than Urgent Care and Emergency Care, you will be responsible for any balance due to the provider above Medicare Allowable Amounts.

HOW THE PLAN WORKS

Your Group healthcare plan is an Exclusive Provider Organization (EPO) Plan whereby you obtain all routine covered services from In-network Providers/Practitioners within the PHP Provider network or from our MP/PHCS Providers outside of New Mexico.

IN-NETWORK PROVIDERS

You may choose an In-network Primary Care Provider (PCP) to coordinate your care. In-network PCPs are Provider who have a contract with PHP to provide, coordinate, and manage your healthcare needs. In-network PCPs include family and general practice, internal medicine, and pediatric Provider who are conveniently located throughout the EPO network area. When you see an In-network PCP or any other In-network Provider/Practitioner, you pay a Deductible and/or Copayment for most services. The In-network Provider/Practitioner handles any necessary Prior Authorizations for you.



In-network OB/GYNs can be seen. This benefit, called Open Access, allows female Members to see their OB/GYN for care related to pregnancy or any gynecological condition.

If you want to know more about your In-network Provider/Practitioner, the Presbyterian Customer Service Center can tell you information such as medical school attended, residency completed, and board certification status.

OUT-OF-NETWORK PROVIDERS

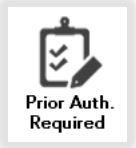
Out-of-network providers are those providers that are not part of the PHP provider network. Services provided by Out-of-network Providers other than in Out-of-network Student Health Centers, and except for injury, urgent or emergency care, are excluded under this Plan.

HOW TO ACCESS CARE

Though not required, it is highly recommended that you select an In-network PCP to coordinate your health care needs. Your In-network PCP will be able to meet most of your health care needs. A list of In-network PCPs can be found in the PHP Provider Directory or on PHP website at **www.phs.org**. You may choose any doctor or nurse practitioner on that list as your In-network PCP. If you choose an In-network PCP from this list and notify PHP of your selection, that PCP information will appear on your ID Card.

WHAT IS PRIOR AUTHORIZATION?

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



The **Prior Authorization** requirements affect whether the Plan pays for your Covered Services. However, **Prior Authorization** does not deny your right to be admitted to any Hospital. You make the best use of your Covered Benefits. You should keep this Summary Plan

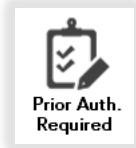
IMPORTANT: If you have Coverage that includes Dependent or Family Medical Coverage, **Prior Authorization** requirements apply to your family Members who are also covered persons.

WHAT PROCEDURES REQUIRE PRIOR AUTHORIZATION?

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

- In-network Provider - When accessing services from an In-network Provider, the In-network Provider is responsible for obtaining **Prior Authorization** from Presbyterian Health Plan before providing these services to you.

PRIOR AUTHORIZATION – INPATIENT



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

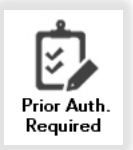
If Presbyterian Health Plan determines that the Admission was for a covered service but hospitalization was not Medically Necessary, **no** benefits are paid for Inpatient room and board charges and these expenses do **not** apply toward the Out-of-pocket Maximum. Other Covered Services are paid as explained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

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

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

PRIOR AUTHORIZATION – OTHER MEDICAL SERVICES

Prior Authorization requirements are subject to change at the discretion of Presbyterian Health Plan with the approval of the Albuquerque Public Schools. Contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5600** or **1-888-275-7737** (**TTY** user may call **711**) to verify services requiring Prior Authorization.



In addition to **Prior Authorization** for all Inpatient services, Prior Authorization is required for the following services. For certain services, Prior Authorization may be requested over the telephone. If Prior Authorization is not obtained for the following services, benefits will be reduced or denied for all related services. Your In-network Provider will request Prior Authorizations for you. Discuss the need for Prior Authorizations with your Provider before obtaining any of the following services:

- Acute Medical Detoxification (listed under Behavioral Health and Alcoholism and/or Substance Use Services in the Covered Benefits Section)
- All Hospital admissions, Inpatient non-emergent (listed under Hospital Services-Inpatient in the Covered Benefits Section)
- Applied Behavior Analysis
- Bariatric Surgery and Surgery for the treatment of obesity
- Bone Growth stimulators;
- Cancer Clinical Trials (Investigational/Experimental)
- Clinical Trials (Investigational/Experimental) (listed under Clinical Trails in the Covered Benefits Section)
- Certified Hospice Care
- Computed Axial Tomography (CAT) scans in an outpatient setting (listed under Diagnostic and Imaging Services in the Covered Benefits Section)
- Durable Medical Equipment (listed under Durable Medical Equipment, Appliances, Hearing Aids, Medical Supplies, Orthotics, and Prosthetics Subsection)
- Electroconvulsive Therapy (ECT)

- Epidural Injections for Back Pain
- Foot Orthotics (listed under Orthotic Appliances in the Covered Benefits Section)
- Genetic Testing
- Home Health Care Services/Home Health Intravenous Drugs (listed under Home Health Care Services/Home Intravenous Services and Supplies in the Covered Benefits Section)
- Magnetic Resonance Imaging (MRI) in an outpatient setting (listed under Diagnostic and Imaging Services in the Covered Benefits Section)
- Mental Health services - Inpatient, Partial Hospitalization and select outpatient services (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the Covered Benefits Section)
- Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring Systems
- Newborn Delivery and Hospital Obstetrical services (listed under Maternity Care in the Covered Benefits Section)
- Non- emergency care when traveling outside the U.S.
- Nutritional Supplements (listed under Nutritional Support and Supplements in the Covered Benefits Section)
- Observation Services greater than **24 hours**
- Organ transplants (listed under Transplants in the Covered Benefits Section)
- Orthotics
- Positron Emission Tomography (PET) scans in an outpatient setting
- Some Prescription Drugs/Medications
- Prosthetic Devices (listed under Durable Medical Equipment, Appliances, Hearing Aids, Medical Supplies, Orthotics, and Prosthetics Subsection)
- Proton Beam Irradiation
- Reconstructive and potentially cosmetic procedures (listed under Reconstructive Surgery and also Women's Health Care Services in the Covered Benefits Section)
- 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

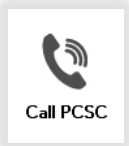
- Special Inpatient services (including but not limited to private room and board and/or special duty nursing)
- Special Medical Foods (listed under Genetic Inborn Errors of Metabolism Disorders (IEM) and also Prescription Drugs/Medications)
- Substance Use Disorder services, Inpatient (listed under Behavioral Health and Alcoholism and/or Substance Use Disorder in the Covered Benefits Section)
- Transplant Services (listed under Transplants in the Covered Benefits Section)
- Transcranial Magnetic Stimulation
- Virtual Colonoscopy (listed under Clinical Preventive Health Services in the Covered Benefits Section)
- Wireless Capsule Endoscopy

CASE MANAGEMENT PROGRAM

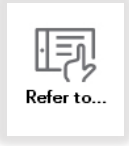
Presbyterian Health Plan's Case Management Program is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive hospitalization, or have complicated discharge planning needs so that cost-effective alternative care arrangements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

TRANSITION OF CARE

If you are a new Member and are in an ongoing course of treatment with an Out-of-network Provider, you will be allowed to continue receiving care from this Provider for a transitional period of time (usually not to exceed **90 days**). Similarly, if you are in an ongoing course of treatment with an In-network Provider and that Provider becomes an Out-of-network Provider, you will be allowed to continue care from this Provider for a transitional period of time. Application must be made within **30 days** of the event. Please contact Presbyterian Customer Service Center, Monday through Friday, 7 a.m. to 6 p.m. at **(505) 923-5600** or **1-888-275-7737** for further information on Transition of Care. TTY users may call **711**.

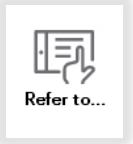


COST SHARING FEATURES



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

COPAYMENT



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

COINSURANCE

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

CALENDAR YEAR DEDUCTIBLE (JANUARY 1 –DECEMBER 31)

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

For Single 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 coverage, the annual Calendar Year Deductible requirement is fulfilled when both Members each meet their individual Deductible listed in the *Summary of Benefits and Coverage*.

For family coverage, with three 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*.

Charges for the In-network Provider services are applied to the Out-of-network Deductible (until the In-network Provider Deductible is met) and vice versa.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

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

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

MAXIMUM BENEFITS

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

MEDICALLY NECESSARY SERVICES

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

- it is medical in nature; and
- it is recommended by the treating Provider;
  it is the most appropriate supply or level of service, taking into consideration:
  - potential benefits;
  - potential harms;
  - cost, when choosing between alternatives that are equally effective;
  - cost-effectiveness, when compared to the alternative services or supplies;
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the Member, the treating Provider, the Hospital, or any other healthcare Provider.

Presbyterian Health Plan determines whether a healthcare service or supply is Medically Necessary and, therefore, whether the expense is covered. (Note: If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a Grievance or complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures" in the Filing Claims Section).

The fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it Medically Necessary or make the expense a Covered Service, even though it is not specifically listed as an exclusion.

HEALTH CARE FRAUD MESSAGE

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

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

If you suspect fraud, please call the Presbyterian Customer Service Center at **(505) 923-5600** or **1-800-275-7737**, Monday through Friday, 7 a.m. to 6 p.m. TTY users may call **711**.

FEDERAL AND STATE HEALTH CARE REFORM

The APS self-funded medical plan and Presbyterian Health Plan (PHP) 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 affect APS's or PHP's obligations under this *Summary Plan Description* will be deemed automatically amended such that APS and/or PHP shall remain in compliance with the obligations imposed by such law, rule or regulation.

EMPLOYEE ELIGIBILITY

Albuquerque Public Schools determines eligibility for employees and their family members, and enrollment procedures. In order to have a complete view of your medical plan benefits as an APS employee, in addition to this *Summary Plan Description* you need to obtain a copy of the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide. These documents are available on the APS website at http://www.aps.edu/human-resources/benefits or from the APS Employee Benefits Department. Important eligibility and enrollment information is included in these APS documents.

Every effort has been made to ensure that the information in this *Summary Plan Description* matches the information in the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide. However, if there are discrepancies between this booklet and the APS documents, the APS documents will supersede this booklet.

Your coverage is one of the following types:

- Employee Only;
- Two-Party, including the employee and his/her spouse/domestic partner or one child; or
- Family, including the employee, his/her spouse/domestic partner, and/or one or more Dependent child(ren).

DEPENDENT ELIGIBILITY

- The employee's spouse through legal marriage and not legally separated from the employee (common law marriages are not recognized under New Mexico State law unless you were in a recognized common law marriage in another state before you moved to New Mexico).

Domestic Partners. A domestic partner is a person of the same or opposite gender who meets the Albuquerque Public Schools qualifying criteria as a domestic partner. Domestic Partners are defined as couples who are in an exclusive and committed relationship for mutual benefit, similar to a marriage relationship in the State of New Mexico. Domestic Partners must share a common, primary residence for **12 or more** consecutive months, and must be jointly responsible for each other's common welfare, as well as shared financial obligations. Domestic Partners must be at least **18 years** of age and may not be married; nor can they be a member of another domestic partnership. Domestic partners are also forbidden from being blood relations to a degree of closeness that would prevent them from being married in the State of New Mexico. Visit or contact the APS Employee Benefits Department for more information and to obtain a copy of the Affidavit of Domestic Partnership that must be completed and submitted to the APS Employee Benefits Department, along with the required supporting documentation outlined in the APS Domestic Partner Policy to determine possible eligibility for domestic partner coverage.

- Married or unmarried children through the end of the month during which the child turns **age 26** as follows:
    - Biological children
    - Legal adoption or legal guardianship of a child. Evidence of placement by state licensed agency, governmental agency, or a court order/decree is required.
    - Stepchildren (or otherwise eligible child(ren) of a domestic partner) or children for who you have court approved legal guardianship.
- Foster child living in the same household as a result of placement by a state licensed placement agency, so long as the foster home is appropriately licensed; evidence of placement and foster home licensure is required.
- Children for whom you have been ordered by a court of law or through administrative order to provide health care coverage.

The employee will be required to provide documentation for proof of eligibility; a Power of Attorney is not considered court approval.

- Children for whom you are legally responsible to provide health care coverage under a qualified medical child support order. A qualified medical child support order is a judgment, decree or order (including approval of a settlement agreement) that states you are legally responsible to provide health care coverage for that child.
- Disabled adult children who are unmarried and who were enrolled on the Plan as Dependents before **age 26**. The attainment of **age 26** shall not terminate the coverage under the Plan of a child who has been medically certified as disabled, is incapable of self-sustaining employment because of mental or physical impairment, and who is chiefly dependent upon you for maintenance and support. You must provide proof of the child's incapacity and dependency within **31 days** of the child reaching **age 26**, and every year after that upon request by the Plan. A child whose coverage has terminated under the Plan due to reaching the age limit for coverage, and then becomes disabled, is not eligible to re-enroll as a disabled adult child.

Extended family members such as the spouse of a child (the employee's son-in-law or daughter-in-law), a divorced spouse, parents, parents-in-law, grandparents or any and other relatives are not eligible under any circumstances. A court order to provide coverage for the extended family member does not require APS to grant eligibility to that Dependent.

If you have questions about your child's eligibility, contact the APS Employee Benefits Department for details and information regarding required supporting documentation to enroll your child.

Benefits are **not** provided for Hospital room and board or Inpatient Provider care for any Hospital Admission or portion of an Admission that is for a Member who is **not covered** or who, at the beginning of the Admission was **not** a Member, an eligible Dependent, or the natural-born child of an employee.

No individual may be covered under the Plan both as an Employee and as a Dependent, nor may any Child be covered as the Dependent of more than one Employee.

It is your responsibility to complete an Enrollment/Change Form in the APS Employee Benefits Department with any change in your coverage status, e.g. to add a newly acquired dependent. It is your responsibility to notify the APS Human Resources Department of a name or address change. APS will notify the Claim Administrator of these changes once you complete the required APS documentation.

The Claim Administrator reserves the right to verify your eligibility for coverage by requesting proof from you or your agency group representative that a valid employer-employee relationship exists and that you otherwise meet all applicable eligibility requirements.

ENROLLING FOR COVERAGE

Albuquerque Public Schools (APS) determines eligibility for employees. Refer to the APS Employee Benefits Handbook or the APS Employee Benefits Enrollment Guide for eligibility information. Every effort has been made to ensure that the information in this *Summary Plan Description* matches the information in the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide. However, if there are discrepancies between this booklet and the APS documents, the APS documents will supersede this booklet.

For new benefit eligible APS employees, eligibility for Plan benefits commences on the first day of the month coincident with or next following date of hire. Date of hire is the first day of regular employment.

You must complete and submit an APS enrollment form within **60 calendar days** from your date of hire or initial eligibility date. If you decline coverage, or if you have not enrolled timely (within **60 calendar days** from your initial hire or eligibility date), you and/or your Dependents will not be eligible to enroll until the next annual Switch/Open Enrollment, unless you qualify for Special Enrollment due to a qualifying life event.

An employee may also enroll for coverage within 60 days of incurring a "change of status/qualifying life event." If you have a qualified change in status or as a result of a special enrollment event, you will be eligible to enroll for coverage within 60 calendar days of the change.

Once you complete an enrollment form, your elections remain in effect through the plan year – from January 1 to December 31. An employee may choose to dis-enroll or cancel coverage at the end of any month ONLY if they are paying their share of insurance premiums on an after-tax basis. **However, if the employee is enrolled in the APS Pre-tax Insurance Premium Payment Plan (PIPP), you may not dis-enroll or cancel your medical coverage until the end of the Calendar Year during Switch/Open Enrollment unless you experience a "change of status/qualifying life event."**

Each year you will have an opportunity, during Switch/Open Enrollment (held by APS each year in October) to change your group health plan elections. The choices you make at Switch/Open Enrollment will be effective the following January 1. Unless otherwise announced by the APS Employee Benefits Department, you and your Dependents will be automatically re-enrolled in the same medical plan option each year unless you complete a new enrollment form changing your election during the Switch/Open Enrollment period. If you are automatically re-enrolled in the same medical plan option for the new plan year, your benefits will be subject to any changes made to the plan design for the new plan year (i.e., changes to copayments, deductible, coinsurance and any changes to covered benefits).

HOW TO ENROLL DEPENDENTS

You may apply for coverage of your eligible dependents, which may mean changing from Employee only coverage to Two-Party or Family Coverage. Each additional Dependent added to your coverage must be enrolled within **60 days** of becoming eligible for the Plan. Newborns are effective on the date of birth, and newly adopted children are effective on the date of placement; any new dependent must be enrolled within **60 days** of that date.

WHEN COVERAGE STARTS

The Plan pays for Covered Services that a Member receives on or after his or her effective date of coverage, as long as a completed Enrollment Form and any required supporting documentation has been submitted to the APS Employee Benefits Department. If you have questions regarding the effective date of your or your Dependents coverage, refer to the APS Employee Benefits Handbook or the APS Employee Benefits Enrollment Guide, or contact the APS Employee Benefits Department.

HEALTH INSURANCE PORTABILITY & ACCOUTABILITY ACT OF 1996 (HIPAA)

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan. You must request enrollment within **31 days** after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within **31 days** after marriage, birth adoption, or placement for adoption. If you have any questions about this law, contact the APS Employee Benefits Department.

CHANGING YOUR COVERAGE

Once you elect coverage, you generally cannot change your elections until the following Switch/Open Enrollment period. However, there are certain circumstances when you may be eligible to change coverage earlier. You must request the change in coverage within **60 days** of

the event causing the change. Any change must be consistent with the reason the change was permitted.

- Situations governed by HIPAA special enrollment rules.
- You, your spouse, or your Dependent children become eligible for Consolidated Omnibus Reconciliation Act (COBRA) continuation coverage.
- Judgment, decree, or order that requires accident or group health coverage for your child.
- You, your spouse, or Dependent children become entitled to Medicare or Medicaid. (You may cancel coverage for the individual who becomes eligible for Medicare or Medicaid coverage.)

- A significant change in the health care provided to you or your Dependents through a third party, such as your spouse's employer.

- Change in status event, but only when the change causes you or your Dependent to gain or lose eligibility for coverage. The change must correspond with the gain or loss of coverage.

Note:
It is your responsibility to complete an Enrollment/Change Form in the APS Employee Benefits Department with any change in your coverage status, e.g., loss or gain of other coverage or to add a newly eligible dependent. It is your responsibility to notify the APS Human Resources Department of a name or address change. APS will notify the Claim Administrator of these changes once you complete the required APS documentation.

FAMILY STATUS OR EMPLOYMENT STATUS CHANGES (QUALIFYING EVENTS)

You may make certain changes to your benefit elections within **60 days** of a change in family/employment status. Evidence of a change in family/employment status must be provided to the APS Employee Benefits Department in order to change your benefit elections. Any change in coverage must correspond with the gain or loss of coverage and will become effective the first of the month following the date the new benefit elections are made by completing an Enrollment/Change Form in the APS Employee Benefits Department. The only exceptions would be birth and adoption, where the additional coverage would become effective retroactive to the date of birth or date of adoption, as long as you enroll the child within **60 days** of that date. The following family/employment status changes are recognized by the APS Employee Benefits Department:

- Marriage or divorce;
- Birth or adoption of a child;
- Death of a spouse or Dependent child;
- A change in your spouse's employment (loss of job, or a new job that provides healthcare coverage, however, annual enrollment for a spouse's plan is not a family status change);

- Marriage of a Dependent child which results in that child enrolling for coverage under his or her new spouse;
- Change in employment status (from a non-benefit eligible status to a benefit eligible status).
- The APS Employee Benefits Department will automatically dis-enroll your child on the last day of the month following that child's 26th birthday (unless the child has been certified as disabled and determined to be eligible to continue coverage as a disabled adult child).

SPECIAL ENROLLMENT/NOTICE OF EMPLOYEE RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you are declining enrollment for yourself or your Dependents (including your spouse and eligible children) because of other group health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan. You must request enrollment within **60 days** after you or an eligible Dependent lose coverage under another group health plan either because:

- Eligibility ends;
- COBRA benefits are exhausted;
- You return to work after serving active military/reserve duty; or
- Employer contributions end.

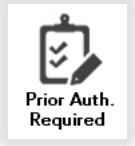
In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within **60 days** after the marriage, birth, adoption, or placement for adoption.

An otherwise eligible employee and Dependent(s) who did not apply for coverage when initially eligible because of other group coverage at another place of employment, but who later lost their coverage due to a change in employment status, may apply within **60 days** if the loss of coverage is due to loss of employment/change in job status, or death of a spouse, or divorce from a spouse. This provision also applies to employees who return to work after serving active military/reserve duty.

ID CARD

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

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



Your Member identification number and your APS group number are on your ID Card. Each of your Dependents will also receive an ID card. If you or your Dependents selected an In-network PCP, their In-network PCP selection and the PCP's telephone number will also be displayed. (If you or your Dependent(s) did not select an In-network PCP, then no PCP information will be

listed on the ID Card.) The reverse side of your ID card provides the address for PHP and some important telephone numbers for your use while using the Plan. It is important that you always show each individual's own ID card when obtaining care.

If you want additional cards or need to replace a lost card, contact a Presbyterian Customer Service Center representative.

This card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. Anyone who knowingly or willfully allows a non-covered person to use their medical plan ID Card to receive benefits shall risk forfeiting all employee and family rights to APS medical plan coverage or benefits.

ELIGIBILITY ENROLLMENT, EFFECTIVE AND TERMINATION DATES

TERMINATION

WHEN COVERAGE ENDS

Employee coverage ends on the earliest of the last day of the month in which:

- your employment ends; or
- your employment contract ends; or
- you enter the Armed Forces (the military) on full-time active duty; or
- you are no longer eligible to participate in the Plan (for example, you are no longer classified as a benefit eligible employee); or
- you cease to make any contributions required for your coverage; or
- you drop coverage at Switch/Open Enrollment or due to a Special Enrollment mid-year change event; or
- the date the Plan is discontinued; or
- the date of your death.

Dependent or Domestic Partner coverage ends on the earliest or the last day of the month in which:

- the Employee's coverage ends; or
- your covered Spouse or Dependent Child(ren) or Domestic Partner no longer meet the definition of Spouse or Dependent Child(ren) or Domestic Partner as defined by APS; or
- you cease to make any contributions required for coverage of your Spouse or Dependent Child(ren) or Domestic Partner; or
- the date the Spouse, or Domestic Partner enters the Armed Forces on full-time active duty; or
- the date Dependent coverage is discontinued under the Plan; or
- the date of the Dependent's or Domestic Partner's death; or
- the date the Plan is discontinued.

You or your Dependents must promptly furnish to the APS Employee Benefits Department information regarding marriage, divorce or legal separation, change in Domestic Partner status, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Refer to the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide for additional information regarding your options for continuation coverage, when the Plan can end your coverage for cause, special circumstances such as leave of absence, and the possible consequences of not providing timely notice to the APS Employee Benefits Department

when you or a covered Dependent have a status change that impacts eligibility for coverage under this Plan.

If a member is admitted to a hospital or treatment facility while they are still enrolled in this plan and their membership/eligibility terminates before they are discharged, this Plan will cover all covered charges thru to discharge.

HOW TO DIS-ENROLL

Refer to the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide for information regarding the steps to take, documentation required, and the circumstances under which an employee may dis-enroll from the Plan, or drop coverage for a dependent.

CERTIFICATE OF COVERAGE

When your coverage ends, the Claim Administrator provides evidence of your prior medical plan coverage by supplying you with a Certificate of Coverage. You may need to furnish this certificate if you become eligible under another group health plan or if you want to buy, for you or your family, an individual insurance policy.

LEAVE OF ABSENCE

Refer to the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide for important information regarding medical plan coverage while you are on an approved APS leave.

During an APS approved leave of absence (such as for FMLA, Military leave or a District-approved leave), you may elect to continue your benefits coverage, provided that you pay your portion of the total required monthly premium. (Details will be included in the letter you receive from the APS Leaves Department.)

While on leave, you are responsible for notifying the APS Employee Benefits Department of any Special Enrollment event (the birth of a baby, marriage, divorce, etc.) and completing an Enrollment/Change Form within **60 days** of the event.

CONTINUATION OF COVERAGE UNDER COBRA

The APS medical Plan is subject to the provisions for continuation of plan coverage under Federal law (COBRA). The employee and his/her covered Dependents who lose eligibility under this Plan may continue as Group Members for a limited period of time.

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

If you are an employee of APS covered by this health care plan, you have the right to choose this continuation coverage if you lose your group health coverage due to a reduction in your hours of employment; or change in employment status from benefit eligible to non-benefit eligible; or the termination of your employment (for reasons other than gross misconduct on your part).

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

- The death of your spouse/domestic partner;
- A termination of your spouse/domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse/domestic partner's hours of employment as outlined above;
- A Divorce or legal separation from your spouse; or
- Your spouse/domestic partner becomes entitled to and enrolls in Medicare benefits.

An eligible child of an employee covered by the Group's health care plan has the right to continuation of coverage if group health care coverage under the APS plan is lost for any of the following reasons:

- The death of the parent employee;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment as outlined above;
- Parent's divorce or legal separation;
- The child ceases to be an eligible child under the plan; or
- The parent employee becomes entitled to and enrolls in Medicare.

Under the COBRA law, the employee or a family Member has the responsibility to inform the APS Employee Benefits Department within **60 days** of the employee's death or of a divorce, legal separation, or a child losing eligibility status under the Group plan.

Should one of the above events occur (and you notify the APS Employee Benefits Department), APS will notify you that you have the right to choose continuation of coverage. Under the COBRA law, you have **60 days** to elect COBRA continuation coverage. The **60 days** begins on the date you lose coverage due to one of these events, or the date the notice of your rights to choose continued coverage is mailed.

If you do not choose continuation of coverage, your APS group health coverage will end. You may have other options for coverage, such as enrolling in a spouse's plan (if applicable) or obtaining coverage through the Health Insurance Marketplace or through Medicaid.

If you elect to enroll for COBRA continuation coverage, APS is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family Members. The COBRA law requires that you be given the opportunity to maintain continuation of coverage for a maximum of **36 months**, unless you lost group health care coverage due to a termination of employment or reduction in hours, in which case the required continuation coverage period is **18 months**, unless you have been determined to be disabled under the Social Security Act, in which case the required continuation coverage period is 29 months. However, this law also provides that your continuation coverage may end for any of the following reasons:
The employer no longer provides group health coverage to any of its employees;
The premium for your continuation coverage is not paid on time;
You become covered under another group health plan; You become entitled to Medicare benefits (coverage may continue for your spouse); or
You are determined to no longer be disabled (shortens the extended period).

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you will pay 102% of the full premium for your continuation coverage.

For more information regarding COBRA, contact the APS Employee Benefits Department.

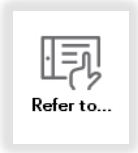
COVERED SERVICES

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

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

ACCIDENTAL INJURY/MEDICAL EMERGENCY CARE/URGENT CARE

MEDICAL EMERGENCY CARE



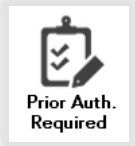
Treatment for a Medical Emergency or Accidental Injury in the Emergency Room of a Hospital or an Urgent Care facility is a benefit. No notification to Presbyterian Health Plan is required. Please refer to the *Summary of Benefits* for Emergency Room Visit or Urgent Care Center Copayments and/or Coinsurance.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

Definition of Emergency: Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health, if pregnant the health of you or your unborn child; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement. Initial treatment must be sought within **48 hours** or as soon as reasonably possible of the accident or onset of symptoms to qualify as emergency care. Acute medical emergency care is available **24 hours** per day, **7 days** a week.

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

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

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



No notification or **Prior Authorization** is required for Out-of-network (including out of state) Hospitals or treatment facilities for Medical Emergency services. However, the Member will be responsible for the Copayment and/or Deductible and Coinsurance as outlined on the *Summary of Benefits*, as well as those charges above what the plan pays for emergency care obtained Out-of-network.

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

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

URGENT CARE

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

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

ACUPUNCTURE SERVICES

Acupuncture treatment is a benefit only if performed by a licensed Provider, Osteopath, or Doctor of Oriental Medicine acting within the scope of his/her license.

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

AMBULANCE SERVICES

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

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

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

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

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

Highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

If Medically Necessary ambulance transportation is required between medical facilities, the ambulance Deductible and/or Coinsurance is waived.

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

There are no benefits when the ambulance transportation is primarily for the convenience of the Member, the Member's family, or the healthcare Provider. If use of an ambulance (air/ground) is determined not to be medically necessary, it can be denied. This includes, but is not limited to, use of an ambulance to transfer a patient to a lower level of care facility or their home.

AUTISM SPECTRUM DISORDER

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

1. Diagnosis for the presence of Autism Spectrum Disorder when performed during a well-child or well- baby screening; and/or

2. Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis (ABA) to develop, maintain, restore and maximize the functioning

of the individual, which may include services that are habilitative or rehabilitative in nature.

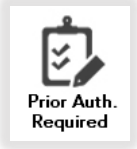
These services are only covered when a treatment plan is provided to Presbyterian Health Plan's Health services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with the state mandate.

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

BEHAVIORAL HEALTH AND ALCOHOLISM AND/OR SUBSTANCE USE DISORDER

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

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



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

Outpatient services are available from the following credentialed Providers:

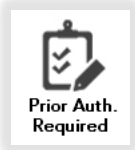
- Medical Doctors, Board Eligible or Board Certified in Psychiatry (M.D.);
- Licensed Psychologists (L.P.);
- Licensed Independent Social Workers (L.I.S.W.);
- Licensed Clinical Mental Health Counselors (L.P.C.C.);
- Licensed Marriage and Family Therapists (L.M.F.T.);
- Clinical Nurse Specialists (C.N.S.);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

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

BEHAVIORAL HEALTH SERVICES

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

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



Partial hospitalization can be substituted for the Inpatient Behavioral Health Services. Partial hospitalization is a non-residential Hospital-based day program attended by the Member at least **3 hours** a day but not more than **12 hours** in any **24-hour** period which includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Inpatient Behavioral Health Services require **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. If **Prior Authorization** is not obtained, the Member will be responsible for Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

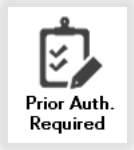
Outpatient, non-Hospital based short-term evaluative and therapeutic Behavioral Health Services will be provided based on medical necessity.

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

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

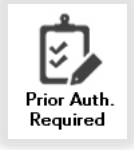
ALCOHOL AND/OR SUBSTANCE USE DISORDER SERVICES

All non-emergency Inpatient services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department; failure to do so will result in benefits being reduced or denied.

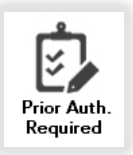


If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required.

All non-emergency Inpatient treatment in a Hospital or Substance Use Disorder treatment center requires **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. If **Prior Authorization** is not obtained, the Member will be responsible for Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*.



Partial hospitalization can be substituted for Inpatient Alcoholism and/or Substance Use Disorder services. Partial hospitalization is a non-residential day program, attended by the Member at least **3 hours** a day but not more than **12 hours** in any **24-hour** period, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Partial hospitalization services require **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. Failure to obtain **Prior Authorization** for services may result in a reduction in benefits (as listed on the *Summary of Benefits*) or a denial of benefit. Please refer to the *Summary of Benefits* for day limitations.



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

Intensive Outpatient Alcohol and/or Substance Use Disorder services are defined as visits lasting up to **9 hours** per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting between 15 and 110 minutes**.**

Coverage includes services for diagnostic tests, anesthetics, x-ray and laboratory examinations, and other care provided by a professional Provider, Hospital.

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

BIOFEEDBACK

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

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

CLINICAL TRIALS

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

A **qualified individual** is someone who is eligible to participate in an approved Clinical Trial according to the trial protocol with respect the treatment of cancer or another life-threatening disease or condition; and either (1) the referring 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 latest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

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

- Any other services provided to clinical trial participants that are necessary only to satisfy the data collections needs of the clinical trial.

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

CARDIAC/PULMONARY REHABILITATION

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

CHEMOTHERAPY/DIALYSIS/RADIATION THERAPY

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

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

CHIROPRACTIC SERVICES

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

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

COVID-19

As a Presbyterian Health Plan Member, there will be no cost to you for anything related to COVID-19 screening, testing, medical treatment, or vaccination. You will not pay copays, deductibles or coinsurance for visits related to COVID-19, whether at a clinic, hospital or using remote care. If you are on a high deductible plan (HDHP), these services will also be provided to you at no cost.

DENTAL CARE AND MEDICAL CONDITIONS OF THE MOUTH AND JAW

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

DENTAL ACCIDENTS

Treatment for conditions that are the direct result of Accidental Injury to the jaw, sound natural teeth, mouth or face is a benefit. Benefits for covered services related to the Accidental Injury are subject to the same limitations, exclusions and member cost-sharing provisions that apply to emergency room or urgent care treatment, or to other similar services when not dental-related (e.g., x-rays, medical supplies, surgical services). Injury because of chewing, biting, or malocclusion is **not** considered an Accidental Injury.

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

To be covered, *initial* treatment for the injury must be sought within **72 hours** of the accident and any services required after the initial treatment must be associated with the initial accident to be covered. All covered treatments for dental trauma must be completed within one year of the specific traumatic injury, and all services subsequent to the initial treatment require **Prior Authorization** by Presbyterian Health Plan. If craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders are a result of trauma such as a bodily injury or blow caused solely through external, violent, and unforeseen means, benefits are available for diagnostic examination, x-rays, medications, physical therapy, dental splints, Acupuncture, orthodontic appliances and treatment, crowns, bridges, and dentures. Trauma does not include injury because of biting, chewing, or malocclusion.

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

HOSPITALIZATION FOR DENTAL CARE

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

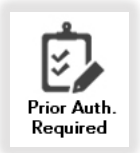
If a Member is admitted for care, **Prior Authorization** is required. If **Prior Authorization** is not obtained, the Member will be responsible for Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*. In-network Providers will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorization** with your Provider. The dental procedure itself is not a covered benefit unless conditions for trauma or oral Surgery are met.

The APS Employee Benefits Department recommends that you contact your dental plan (if you have dental plan coverage) to determine whether you have any benefits for the dental procedure. You may also wish to request a predetermination of benefits from your dental plan.

ORAL SURGERY AND TMJ TREATMENT

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

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



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

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

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

DIABETES SERVICES

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

Covered Benefits are provided if you have insulin dependent (Type 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.

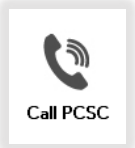
DIABETES EDUCATION

Diabetes education is a covered benefit by referral and includes coverage for any Provider rendering education or instructional services for diabetes.

- Insulin Pump Training - One initial session and one follow up session.
- Type I Diabetes - For Members 18 years of age and under, up to six visits to normalize glucose within 2 months of diagnosis; thereafter, up to one visit per month as needed to maintain control of diabetes. For Members over 18 years of age, up to six visits to normalize glucose within two months of diagnosis; then up to one visit per month for the first year following diagnosis; thereafter, up to four visits per year.
- Type II Diabetes - Up to four visits for initial education, plus if insulin is initiated, up to three visits for insulin start up and management; thereafter, up to four follow up visits per Calendar Year.
- Diabetes Occurring Only During Pregnancy (“Gestational Diabetes”) - One initial visit; thereafter, two follow up visits per month. In addition, one visit within six months following delivery for conception counseling for patients planning additional children.
- Hypoglycemia and Glucose Intolerance - Up to three visits to provide necessary nutritional counseling to delay or prevent onset of diabetes.

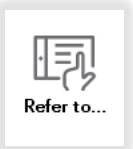
Additional visits - include following a Provider diagnosis that represents a significant change in the patient’s symptoms or condition that warrants changes in the patient’s self-management; or visits when re-education or refresher

DIABETES SUPPLIES AND SERVICES



Diabetes supplies and services when prescribed by the Member's Attending Provider (also refer to your Prescription Drug benefits through Express Scripts) the following equipment, supplies, appliances, and services are available from a Durable Medical Equipment supplier and are covered for Members with diabetes:

- Standard blood glucose monitors;
- Visual reading urine and ketone strips;
- Insulin (covered under your prescription drug benefits through Express Scripts);
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Prescription oral agents for controlling blood sugar levels (covered under your prescription drug benefits through Express Scripts);
- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and show modifications.
- Insulin pumps when Medically Necessary and prescribed by an endocrinologist.



Diabetic supplies, appliances, and equipment obtained from In-network providers are covered at 100% (no patient copayment or coinsurance) under the APS medical plan.

For additional diabetic supply coverage (e.g., insulin needles and syringes, Autolet®, test strips, glucagon emergency kits), call Express Scripts.

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

DIABETIC SUPPLIES AND EQUIPMENT- PREGNANCY RELATED

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

- insulin pump supplies (not to exceed a 30-day supply purchased during any 30-day period);
- injection aids, including those adaptable to meet the needs of the legally blind;
- insulin pumps when Medically Necessary, prescribed by an endocrinologist;
- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications.
- Blood glucose monitors.

Diabetic supplies, appliances and equipment are covered at 100% (no patient copayment or coinsurance) under the APS medical plan.

Discuss the need for **Prior Authorization** with your provider before any of these items are obtained. Some of these items may require **Prior Authorization**.

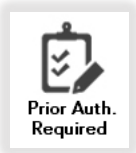
For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), call Express Scripts.

DIAGNOSTIC SERVICES

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

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

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;
- Prenatal genetic testing unless it is determined to be Investigational;
- Chromosome analysis, including karyotyping and molecular cytogenetic testing (may require **Prior Authorization**);
- EKG, EEG, and other electronic diagnostic medical procedures;
- Hearing tests **only** for the treatment of an illness or Accidental Injury (except as outlined below under "Hearing Aids");
- Magnetic Resonance Imaging (MRI);
- Positron Emissions Tomography (PET) scans (require **Prior Authorization**);
- Home/Sleep disorders;
- Allergy testing; and
- CT scans (required Prior Authorization).



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

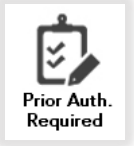
If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required.

DURABLE MEDICAL EQUIPMENT AND EQUIPMENT AND APPLIANCES, HEARING AIDS, MEDICAL SUPPLIES, ORTHOTICS, AND PROSTHETICS

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

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

- The rental or, at the option of Presbyterian Health Plan, the purchase of Durable Medical Equipment when prescribed by a Provider or other professional Provider and required for therapeutic use, including Wheelchairs, Hospital beds, crutches, and other necessary Durable Medical Equipment;
- Purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity;
- Prosthetic eyes;
- Breast Prosthetics when required as the result of a mastectomy;
- Orthotic (a rigid or semi-rigid supportive device) or Orthopedic Appliance (Prefabricated) that supports or eliminates motion of a weak or diseased body part. This does not include foot orthotics, functional or otherwise except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan;
- Contact lenses for aphakia (those with no lens in the eye) or keratoconus;
- Sclera shells (white supporting tissue of eyeball);
- Initially, either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intra-ocular Surgery or ocular injury and prescribed by a Provider. (Duplicates are **not covered,** and replacement is covered only if a Provider or optometrist recommends a change in prescription due to the medical condition.);
- Custom-fabricated knee-ankle-foot orthoses (AFO and/or KAFO) in accordance with existing Medicare guidelines:
- Hearing aids
- School-aged children – hearing aids and the evaluation for fitting of hearing aids are covered for school aged children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount up to a maximum of $2,200 every 36 months “per hearing impaired” ear. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit; Stethoscopes and manual blood pressure cuffs that are prescribed by a Provider. Automatic blood pressure cuffs or monitors are **not covered** unless the Member is physically unable to use a manual cuff; and



- Repairs or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the Member’s condition, or after the product’s normal life expectancy has been reached and when **Prior Authorization** is obtained from Presbyterian Health Plan.

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

Surgically implantable devices and prostheses are covered as follows:

- Surgically implanted Prosthetics or devices, including penile implants required as a result of illness or injury;
- Implantable mechanical devices such as cardiac pacemakers or defibrillators, insulin pumps, epidural pain pumps, and neurostimulators;
- Intra-ocular lenses;
- Cochlear implants (see "Surgery" for additional information about benefits available for cochlear implantation);
- Teflon®/Dacron® surgical grafts and meshes; and
- Artificial or porcine heart valves.

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

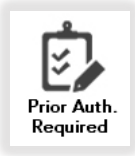
MEDICAL SUPPLIES

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

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

Prior Authorization from Presbyterian Health Plan is required for:

- Durable Medical Equipment, medical supplies (including enteral feeding tubes), orthopedics appliances, orthotics, and surgically implanted Prosthetics

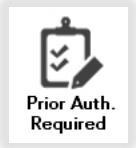


In-network Providers will request **Prior Authorization** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied.

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

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

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



FAMILY, INFANT AND TODDLER (FIT) PROGRAM

Coverage for children, from birth to age three, for or 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 as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & children Health Care Services. Benefits used under this section will not be applied to any maximum lifetime or annual plan limits applicable to this plan. This benefit is subject to an annual maximum.

FAMILY PLANNING AND RELATED SERVICES

Family planning services are covered for the following procedures:

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

Oral contraceptives are covered under the prescription drug benefit through Express Scripts.

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

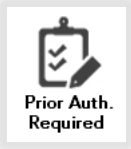
- Surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is not the result of a surgical sterilization; and
- Replacement of deficient, naturally occurring hormones if there is documented evidence of a deficiency of the hormone being replaced.

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

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

GENETIC INBORN ERRORS OF METABOLISM DISORDERS (IEM)

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

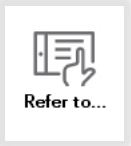


diagnosed with Genetic Inborn Errors of Metabolism (IEM) are Covered. Covered Services include:

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

For prescription drug contact Express Scripts.

Please refer to your *Summary of Benefits* for applicable office visit, Inpatient Hospital, Outpatient facility, and other related Copayments.



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

HABILITATIVE

AUTISM SPECTRUM DISORDER

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

1. Diagnosis for the presence of Autism Spectrum Disorder when performed during a well-child or well- baby screening; and/or

2. Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis (ABA) to develop, maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative in nature.

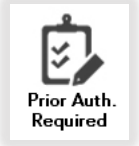
These services are only covered when a treatment plan is provided to Presbyterian Health Plan's Health services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with the state mandate.

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

HOME HEALTH CARE

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

Before the Member receives home health care, the treating Provider or Home Health Agency must request **Prior Authorization** from Presbyterian Health Plan. In-network Providers request **Prior Authorization** for you.



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

- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- Physical, occupational, or respiratory/inhalation therapy, by licensed or certified therapists, and speech therapy provided by an American Speech and Hearing Association certified therapist;
- Skilled services by a qualified aide to do such things as change dressings, check blood pressure, pulse, and temperature;
- Medical supplies, drugs, and laboratory services that would have been provided by a Hospital had the Member been hospitalized;
- Provider home visits;
- Home Intravenous services; and
- Enteral feeding equipment and food.

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

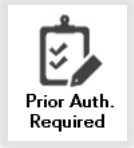
- Is provided primarily for the convenience of the Member or the Member's family;
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter; or
- Is provided by a nurse who ordinarily resides in the Member's home or is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

HOSPICE CARE

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

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

Before the Member receives Hospice care, the treating Provider or Hospice agency must request **Prior Authorization in writing** from Presbyterian Health Plan. **Prior Authorization** requires a written treatment program approved by the treating Provider. In-network Providers request **Prior Authorization** for you.



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

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

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

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

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

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

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

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

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

- Food, housing, or delivered meals;
- Medical transportation;

- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing; and
- Pastoral and spiritual counseling.

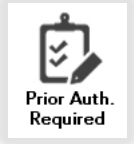
The following services are **not** benefits under Hospice but may be covered elsewhere under this booklet, subject to applicable Copayment, and Coinsurance provisions:

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

HOSPITAL INPATIENT SERVICES

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

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



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

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

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

BLOOD

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

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

PHYSICAL REHABILITATION – INPATIENT

Benefits are available for Inpatient rehabilitation services that are Medically Necessary to restore and improve lost functions following illness or Accidental Injury. Hospitalization for rehabilitation must begin within one year after the onset of the condition and while the Member is covered under this Plan. Inpatient rehabilitation treatment must be Medically Necessary and **not** for personal convenience.

These Inpatient services are not eligible for any additional benefits on an Outpatient basis.

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

MASSAGE THERAPY

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

MATERNITY AND NEWBORN CARE

Benefits include complete prenatal care, pregnancy related diagnostic tests, visits to an obstetrician, Certified Nurse-Midwife, or Licensed Midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse-Midwife or Provider. Benefits are not available for delivery at home by a Midwife. Deliveries by cesarean section, ectopic pregnancies, other pregnancy complications, such as miscarriage are also covered.

Prescription drugs administered in the hospital are covered under this medical plan. Prescription drugs obtained from a pharmacy may be covered under the APS prescription drug benefit administered by Express Scripts. Contact Express Scripts with questions.

If Maternity benefits change during a pregnancy, the Member receives the benefits in effect on the day the service is received. Under Coverage that includes dependents an unmarried Dependent daughter is eligible for Maternity benefits. Coverage for the newborn is available ***only*** if covered as an eligible Dependent.

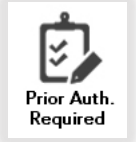
Note:
To add coverage for your newborn child, you must enroll your child as a Dependent within **60 days** of birth. To enroll the baby, contact the APS Employee Benefits Department and be prepared to submit the hospital-provided Proof of Birth or the baby's birth certificate. The baby is then covered from the moment of birth. If you have Employee coverage, you must change to Two-Party Coverage; if you have Two-Party Coverage, you must change to Family Coverage; if you already have Family Coverage, you still must complete the APS Employee Benefits Department enrollment procedures to add your newborn as a Dependent. If you do not enroll your newborn child within **60 days** of birth, you must wait until the next Switch/Open Enrollment period held by APS to enroll the child.

If the newborn is enrolled within **60 days**, the Plan pays benefits for your newborn's services, including newborn visits in the Hospital by the baby's Provider, circumcision, incubator, and routine Hospital nursery charges. If your newborn needs special care including diagnostic tests and Surgery, the Plan pays benefits for that care too. A separate Inpatient Copayment, (or Deductible and/or Coinsurance for Out-of-network care) for your newborn applies only when the infant's Inpatient Stay exceeds the mother's date of discharge. Additional services above and beyond routine newborn care are not subject to an additional Copayment if the infant is discharged on the same day or before the mother is discharged from the Hospital.

If your newborn stays in the Hospital longer than the mother does, you must notify the Presbyterian Health Plan Customer Service Center by calling **(505) 923-5600** or **1-888-275-7737** before the mother is discharged from the Hospital, to coordinate the baby's care, or benefits may be reduced or denied.

NEWBORN AND MOTHERS HEALTH PROTECTION ACT

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



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

PROVIDER SERVICES

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

ALLERGY SERVICES

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

CHRONIC PAIN TREATMENT

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

CONTRACEPTIVE DEVICES

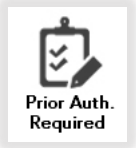
Benefits are available for contraceptive devices that require a prescription by a Provider including:

- IUDs;
- Diaphragms, and
- Other implantable devices

If you must obtain the IUD, or a diaphragm from a pharmacy, you will have to pay for the item and then file a claim to the Presbyterian Health Plan. All other contraceptive devices that do not require a prescription are not a benefit. For oral contraceptive prescription drug benefits, see the Express Scripts *Summary of Benefits* or call them at **1-866-563-9297**.

INJECTABLE DRUGS

FDA-approved therapeutic injections administered in a Provider's office are covered. However, certain injectable drugs (such as growth hormone and interferon alfa-2) are covered only when **Prior Authorization** is received from Presbyterian Health Plan. Your Presbyterian Health Plan contracted Provider has a list of those injectable drugs that require **Prior Authorization**. If you need a copy of the list, contact one of our Presbyterian Customer Service Center representatives, Monday through Friday 7 a.m. to 6 p.m. at **(505) 923-5600** or **1-888-275-7737**. **TTY** users may call 711.



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

Injectable drugs not administered in a Provider's office and instead filled by prescription, may be covered under the APS prescription drug plan. Some injectable drugs may need to be filled via home delivery instead of at a retail pharmacy. Contact Express Scripts at **1-866-563-9297.**

INPATIENT PROVIDER VISITS AND CONSULTATIONS

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

OFFICE VISITS

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

PHP VIDEO VISITS

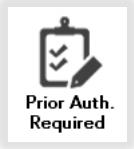
Provided online between a designated Provider and patient about non-urgent healthcare matters. Benefits are available In-network ONLY, when utilizing the Presbyterian Health Plan myPRES dashboard. Offered at $0 copayment on the APS plan, this convenient option offers a way to see a medical provider for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

TELEHEALTH

Appointments through video or telephone are with a network provider, including Presbyterian Medical Group providers. They require most members to pay a normal copayment or cost sharing, just like with an in-person visit.

WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING

Weight loss management, obesity treatment, and nutritional counseling are not benefits unless dietary advice and exercise are provided by a Provider, licensed nutritionist, or registered dietician. Weight loss management, obesity treatment, and nutritional counseling must be prescribed by a licensed Provider and are a benefit only when Medically Necessary and for a body mass index (BMI - weight in kilograms divided by height in meters squared) of 40 or more. Weight loss medications require Pre-Approval by Express Scripts, the company that supplies pharmacy services for APS employees. Express Scripts can be reached at **1-866-563-9297**.



Some Medical services associated with obesity treatment require **Prior Authorization**. If you access care through an In-network Provider, they will obtain **Prior Authorization** when necessary. Also, see Morbid Obesity.

SECOND OPINIONS

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

PREVENTIVE SERVICES

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

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

PREVENTIVE SERVICES FOR 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
- Counseling for HIV, sexually transmitted diseases and domestic violence and abuse.
- Domestic and interpersonal violence screening and counseling for all women.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Contact Express Scripts at **1-866-563-9297**.
- 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.
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling.
- Sexually Transmitted Infections (STI) counseling for sexually active women.

- Sterilization services for women only. Other services during procedure are subject to copayment, deductible and/or coinsurance as outlined in your Summary of Benefits.
- 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 Health Resources & Services Administration https://www.hrsa.gov/womens-guidelines-2019.

CYTOLOGIC SCREENING (PAP SMEAR SCREENING)

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

EVIDENCE-BASED ITEMS OR SERVICES

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

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

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

HUMAN PAPILLOMAVIRUS (HPV) SCREENING

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

HEALTH EDUCATION AND COUNSELING

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

- If you are 20 years of age or older, you may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. Included in the consultation may be, but not limited to:
  - Smoking control

- Nutrition and diet recommendations
- Exercise plans
- Lower back protection
- Immunization practices
- Breast self-examination
- Testicular self-examination
- Use of seat-belts in motor vehicles
- Other preventive healthcare practices

- If you are under age 20, educational materials or consultation to discuss lifestyle behaviors that promote health and well-being including, but not limited to:
  - The consequences of tobacco use
  - Nutrition and diet recommendations
  - Exercise plans
  - As deemed appropriate by the Attending Provider or as requested by the parents or legal guardian for children under 18, educational information on alcohol and substance use disorder, sexually transmitted diseases and contraception.

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

MAMMOGRAPHY COVERAGE

The United States Preventive Services Task Force (USPSTF) recommendations are:

- Biennial screening mammography for women aged 50 to 74 years
- The decision to start screening mammography in women prior to age 50 years should be an individual one.

PROSTATE EXAMS

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

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

ROUTINE VISION SCREENING

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

ROUTINE HEARING SCREENING

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

ROUTINE IMMUNIZATIONS

Routine immunizations are not subject to Copayments when provided by an In-network Provider, to include flu shots and other covered adult immunizations including pneumococcal vaccine, diptheria/tetanus, meningitis, and hepatitis when clinically appropriate as determined by Presbyterian Health Plan. However, you will be responsible for the appropriate Coinsurance/Deductible if immunizations are obtained from an Out-of-network Provider. Immunizations for travel are not Covered. Immunizations for employment are not a covered benefit.

ROUTINE PHYSICAL EXAMINATIONS

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

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

- Periodic blood cholesterol;
- Periodic stool examination for the presence of blood for adults **45** years of age or older;
- Periodic left-sided colon examination of 35 to 60 centimeters for Members **age 45** or older; and
- Periodic glaucoma eye tests for Members **age 35** or older.

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

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

WELL-CHILD CARE

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

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

ROLFING

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

SKILLED NURSING FACILITY

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

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

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

SMOKING CESSATION

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

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

- Is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow up.

- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying a Member's attendance.

- Employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities.

- Uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

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

SURGERY

Benefits are available for the following surgical services:

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

Cosmetic or plastic Surgery or reconstruction procedures, such as breast augmentation, rhinoplasty, surgical alteration of the eye, and surgical correction of prognathism, that Presbyterian Health Plan determines are not required to materially improve the physiological function of an organ or body part are **not** Covered Services. Services for the reconstruction of surgically induced scars are not benefits under any circumstances. Also, most surgeries require a **Prior Authorization.** In-network Providers request **Prior Authorization** for you. Discuss the need for **Prior Authorization** with your Provider.

CARDIAC SURGERY

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

CATARACT SURGERY

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

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

COCHLEAR IMPLANTS

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

CONGENITAL ANOMALIES

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

MORBID OBESITY

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

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

ORAL SURGERY

See “Dental Care and Medical Condition of the Mouth and Jaw” in this section.

OUTPATIENT SURGERY

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

RECONSTRUCTIVE SURGERY

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

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

MASTECTOMY SERVICES

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

When breast reconstruction is chosen, Covered Services include:

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

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

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

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

THERAPY

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

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

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

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

RESTORATIVE SPEECH THERAPY

Restorative speech therapy, in conjunction with a covered illness or injury, includes an additional benefit through the Plan to restore speech. Benefits are limited as shown in the *Summary of Benefits*.

To be eligible for this additional coverage, the Member must have a documented potential for improvement. This therapy excludes coverage for Members with normal physical development but having speech intelligibility limitations. Also excluded are stuttering conditions and Maintenance Therapy.

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

TRANSPLANT SERVICES

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

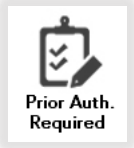
Prescreening at the time of the transplant evaluation and services necessary to complete the evaluation are included in the Transplants benefit as shown in the *Summary of Benefits*.

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

- Kidney/pancreas
- KidneyLiver
- Lung
- Pancreas
- Intestine
- Or small bowel/liver

Also covered are islet cell infusion and autologous or allogeneic bone marrow transplants, including peripheral stem cell, as determined to be Medically Necessary. To be covered, transplant services must also be received within one year of the transplant or re-transplant.

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



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

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

In addition, benefits are available only when the transplant is performed at a facility with a transplant program approved by Presbyterian Health Plan. Call the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5600** (in Albuquerque), or toll-free within New Mexico at **1-888-275-7737** for a current list of Presbyterian Health Plan approved programs. TTY users may call **711.**

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

Organ Procurement or Donor Expenses: If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver are also covered. If there is a living donor that requires Surgery to make an organ available for a covered transplant (e.g., kidney or liver),

coverage is available for expenses incurred by the donor for travel (if required, covered under the "Transplant" provision, and approved by the Presbyterian Health Plan case manager), Surgery, organ storage expenses, and Inpatient follow-up care only.

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

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

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

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

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

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

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

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

LIMITATIONS

The following benefits have limits applied:

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

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

Autism Spectrum Disorder- Service received under the federal individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services.

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

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

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

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

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

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

Consumable Medical Supplies
Consumable medical supplies are covered during Hospitalization. They are also covered during an office visit or authorized home health visit. Presbyterian Health Plan does not cover supplies used at other times by the Member or Member's family. Consumable medical supplies are (1) usually disposable; (2) cannot be used repeatedly by more than one individual; (3) are primarily used for a medical purpose; (4) generally are useful only to a person who is ill or injured; and (5) are ordered or prescribed by a licensed Provider.

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

Dental Services
Dental prostheses, craniomandibular joint (CMJ) and temporomandibular joint (TMJ) disorders, pediatric anesthesia and oral Surgery benefits are Covered when Medically Necessary, but limited to the least costly treatment alternative. Also, this Plan covers only those procedures listed as covered benefits. This Plan does not cover any other oral or dental procedures such as, but not limited to the following:

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

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

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

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

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

Home health care services require **Prior Authorization** or no benefits are payable through the Plan.

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

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

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

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

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

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

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

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

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

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

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

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

If you obtain services from an In-network Participating Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required.

Respite care Respite care for a Hospice caretaker is limited as shown on the *Summary of Benefits*.

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

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

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

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

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

Substance Use Disorder benefits for Residential Treatment Center are limited to a Calendar Year maximum as outlined in the Summary of Benefits. All Inpatient services require **Prior**

Authorization from Presbyterian Health Plan to be considered an eligible expense under this Plan.

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

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

EXCLUSIONS

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

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

Adoption/Surrogate expenses are not a covered benefit.

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

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

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

Autopsies are not a covered benefit under this Plan.

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

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

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

- Any care which is patient elected and is not considered Medically Necessary;
- Care which is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider;
- Workers' Compensation or disability claims are **not covered** as part of treatment;
- Long term Custodial Care of children and adolescents;
- Special education, school testing and evaluations, counseling, therapy or care for learning deficiencies or education and developmental disorders;
- Behavioral problems unless associated with manifest mental illness or other disturbances; and

- Non-national standard therapies, including Experimental as determined by the Behavioral Health professional practice.

Behavioral training is not a covered benefit under this plan.

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

Charges:

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

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

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

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

Convalescent care or rest cures.

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

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

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

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

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

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

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

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

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

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

Duplicate coverage including, but not limited to the following:

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

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

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

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

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

Environmental control expenses are not covered benefits under this Plan.

Exercise equipment is not a covered benefit under this Plan.

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

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

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

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

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

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

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

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

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

- The Plan pays 100% of the allowed up to a maximum of $2,200 every 36 months "per hearing impaired ear" for school aged dependent children.

- Coverage includes fitting and dispensing services, including ear molds as necessary to maintain optimal fit.

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

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

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

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

Hospice benefits are not available for the following services:

- Food, housing, or delivered meals;
- Medical transportation;
- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing;
- Pastoral and spiritual counseling.
- Volunteer services; and
- Support services provided to the family when the patient is not a Member of this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

Maintenance or long-term therapy or care or any treatment (Inpatient or Outpatient) that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice benefit period) is **not covered** under this Plan. In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your Provider supporting his/her opinion that your rehabilitative potential has not been reached. Note: Even if your rehabilitative potential has not yet been reached, this Plan does not cover services that are in excess of maximum benefit limitations outlined in the *Summary of Benefits*.

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

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

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

Membership fees are not a covered benefit under this Plan.

Meniscal Transplants are not a covered benefit under this Plan.

No Legal Payment Obligations are not covered for:

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

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

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

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

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

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

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

Non-prescription vitamins, dietary/nutritional supplements, special foods, formulas, or diets are **not covered** under this Plan.

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

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

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

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

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

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

Orthoptics are not a covered benefit under this Plan.

Orthotripsy is not a covered benefit under this Plan.

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

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

Physical examinations and/or immunizations for purposes of employment, insurance, premarital or international travel tests, sports, school, camp, other non-preventive tests, and those requested by a third party, are **not covered** under this Plan unless considered Medically Necessary by the Plan. If APS requires an annual preventive exam for employees and enrolled spouses/domestic partners to participate in the wellness incentive program, that annual exam is a covered benefit on this Plan.

Post-termination care: Except as otherwise required by applicable law this Plan does not cover services received after your coverage is terminated, even if **Prior Authorization** for such services were needed because of an event that occurred while you were covered.

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

Prescription drugs obtained on an Outpatient basis are not covered under the medical portion of this Plan. If you have questions about your Outpatient prescription drug benefits, contact Express Scripts at **1-866-563-9297**.

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

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

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

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

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

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

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

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

Sperm storage is not a covered benefit under this Plan.

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

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

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

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

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

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

Unreasonable charges will not be covered by this Plan.

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

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

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

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

Vitamins, dietary/nutritional supplements, special foods, formulas, or diets are **not covered** under this Plan.

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

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

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

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

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

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (The Albuquerque Public Schools medical plan may pay claims during the appeal

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

This Plan does not cover a work-related illness or injury, even if:

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

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

FILING CLAIMS

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

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

EMERGENCY SERVICES OR OUT-OF-NETWORK PROVIDERS

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

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

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

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

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

OUT-OF-NETWORK SERVICE CLAIMS

When you obtain Provider or Outpatient Hospital services from an Out-of-network Provider, the Provider, Hospital, Provider or you should file the claims with Presbyterian Health Plan. If the Provider or Hospital does not file the claims, ask for an itemized statement and complete a Presbyterian Health Plan claim form for the services received from the out-of-network Provider. The provider may require that you pay for services up-front and then wait for the Presbyterian Health Plan to process the claim (see "How Payments are Made" below). Out-of-network providers are not required to accept the Presbyterian health Plan determined allowable amount as payment in full, and may balance-bill you the difference between the allowed amount of this Plan and the amount they charged for their services.

CLAIMS OUTSIDE THE UNITED STATES

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

ITEMIZED BILLS

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

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

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

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

PRESCRIPTION DRUG CLAIMS

If you need to submit a claim for Presbyterian Drugs, that claim must be sent to the APS prescription drug Plan Administrator, not a Presbyterian Health Plan. Please refer to Express Scripts Summary of benefits or call them at **1-866-563-9297** for the claims filing procedures for Prescription Drugs.

HOW PAYMENTS ARE MADE

Payments to Out-of-network Providers are sent to the Member unless the Member has assigned benefits to the provider. When possible, this Plan will honor an assignment of benefits; however, Presbyterian Health Plan reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits to pay anyone other than the subscriber in any circumstances.

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

If you obtain services from an Out-of-Network Provider, you are responsible for any amounts greater than Medicare Allowable Amounts. (This may not apply to Emergency Medical Services or Urgent Care Services). You are also responsible for paying all Copayments, Deductibles, Coinsurance, and non-covered services. If the Provider required that you pay for services up-front, and Presbyterian Health Plan makes payment to the Provider for the claim, you will need to contact the Provider to request reimbursement of any amount owed to you. If Presbyterian Health Plan made payment to you, you are responsible for making payment to the Provider.

Payment of benefits for Members eligible for Medicaid is made to the New Mexico Human Services Department or to the Medicaid provider when required by law.

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

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

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

OVERPAYMENTS

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

COORDINATION OF BENEFITS

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

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

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

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

1. No COB Provision. If the other valid coverage does not include a COB provision, that coverage pays first and this Plan pays secondary benefits.

2. Employee/Dependent. If the Member who received care is covered as the employee under one plan/coverage and as a Dependent under another, the employee's coverage pays first. If the Member is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a Dependent of an active employee, then the order of benefit determination is:

   a. benefits of the plan of an active worker covering the Medicare beneficiary as a Dependent;
   b. Medicare;
   c. benefits of the plan covering the Medicare beneficiary as the policyholder or as an active or retired employee.

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

3. Dependent Child/Parents Not Separated or Divorced. If the Member who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the other valid coverage does not follow the birthday rule, then the gender rule applies (that is, the male parent's coverage pays first).

4. Child/Parents Separated or Divorced. If two or more plans cover a Member as a Dependent child of divorced or separated parents, benefits for the child follow these rules:

   a. Court-Decreed Obligations. Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's healthcare expenses, the coverage of that parent pays first.
   b. Custodial/Non-Custodial. The plan of the parent with custody of the child pays first. The plan of the spouse of the parent with custody of the child pays second. The plan of the parent not having custody of the child pays last.
   c. Joint Custody. When a court decree specifies that the parents share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plans covering the child follow the order of benefit determination rules applicable to children whose parents are not separated or divorced.

5. Active/Inactive Employee. If the Member who received care is covered as an active employee under one plan/coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active employee under one plan/coverage and as the Dependent of the *same* but *inactive*

employee under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

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

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

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

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

EFFECT OF MEDICARE ON BENEFITS

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

If you are a working employee **age 65** or over and your spouse is **age 65** or over, you are eligible to continue the Albuquerque Public Schools Plan coverage on the same basis as Members under **age 65**. You may also elect to drop your APS coverage within **60 days** of the date you enroll for Medicare, as long as you complete an Enrollment/Change Form and provide proof to the APS Employee Benefits Department that you have enrolled for Medicare. Benefits will end at the end of the month in which you elect to drop coverage. (If an employee drops medical plan coverage because he or she elected to enroll in Medicare, coverage will also end for an enrolled spouse/domestic partner and/or enrolled child or children; these Dependents may elect COBRA continuation coverage.)

Your third option is to both continue coverage in the APS medical plan, and enroll for Medicare. If Medicare coverage coexists with this Plan, this Plan will be primary for the employee and Medicare will be secondary. (The exception to this rule is when entitlement for Medicare is on the basis of end-stage renal disease. In that case, Medicare will be secondary until the Plan pays

primary for at least 30 months from the date the Member became eligible for or entitled to Medicare on the basis of end-stage renal disease.)

EFFECT OF MEDICAID ON BENEFITS

Benefits payable on behalf of a Member who is qualified for Medicaid is made to the New Mexico Human Services Department or to the Medicaid provider when required by law.

SUBROGATION

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

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

ASSIGNMENT OF BENEFITS

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

FRAUDULENT APPLICATION OR CLAIM

If you knowingly make a false statement on your enrollment Application or file a false claim, such Application or claim will be revoked retroactively back to the date of the Application or claim.

If a claim is paid by the APS medical Plan and it is later determined that the claim should not have been paid due to fraudulent enrollment or claim, the Member shall be responsible for full reimbursement of the claim amount to the APS Plan. Anyone who knowingly or willfully makes any false or fraudulent statement or representations shall risk forfeiting all employee and family member rights to coverage or benefits. APS will take the appropriate disciplinary action against the offending employee.

GRIEVANCE PROCEDURES

Overview
Many Grievances or problems can be handled informally by calling Presbyterian Health Plan (PHP) at **(505) 923-5600** or **1-888-275-7737.**

PHP has established written procedures for reviewing and resolving your Grievances and concerns. There are two different procedures, depending on the type of Grievance.

If your Grievance concerns a decision by PHP to deny, reduce or terminate a requested healthcare service because it is either not a Covered Benefit or it is not Medically Necessary, the Grievance will be subject to the adverse determination Grievance review procedure. See "Adverse Determination Review Procedures" in this Section.

Administrative Grievances: If your Grievance concerns any other action or inaction by PHP concerning any other aspect of PHP's health benefits plan, other than the request for healthcare services, including but not limited to, administrative practices of the healthcare insurer that affect the availability or delivery of healthcare services, claims payment, handling or reimbursement for healthcare services and terminations of Coverage, then the Grievance will be subject to the administrative Grievance review procedure. See "Administrative Grievance Procedures" in this Section.

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

You may request a copy and detailed written explanation of the Grievance procedures by calling PHP at **(505) 923-5600** or **1-888-275-7737**.

Members have **180 days** from the date of the initial denial to file an Appeal with Presbyterian Insurance Company.

ADVERSE DETERMINATION REVIEW PROCEDURES

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

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

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

Phone: (505) 923-5600 or **1-800-275-7737**
Fax: (505) 923-6111
Email: gappeals@phs.org

PHP's internal adverse determination Appeal review procedures require an initial review by a PHP medical director. The review must be completed within **72 hours** when the circumstances require expedited review or within **20 working days** for all other cases. If PHP's medical director decides to uphold the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the medical director's decision by telephone and mail.

ADMINISTRATIVE GRIEVANCE PROCEDURES

If you are dissatisfied with a decision, action or inaction of Presbyterian Health Plan (PHP) regarding a matter that does not involve the denial, reduction or termination of a requested health service, then you have the right to request, orally or in writing, that PHP internally review the matter. First, a PHP representative will review the Grievance and provide you with a written decision within **15 working days** from receipt of the Grievance.

ALBUQUERQUE PUBLIC SCHOOLS GRIEVANCE REVIEW PROCEDURES

If the grievant is not satisfied with PHP's decision under either category above, he/she may appeal the decision within **30 days** of the day the Grievance decision was made. (Note: You may contact Albuquerque Public Schools (APS) at any time during the Grievance process.) Upon receipt of a written appeal request, the APS Employee Benefits Department will review the case and respond to the parties involved within **30 days**. If the appeal is due to an emergency situation, a response will be given within **48 hours** of receipt of such formal appeal request.

By mail: Albuquerque Public Schools
Attn: Employee Benefits Department
PO Box 25704
Albuquerque, NM 87125-0704

Hand-Delivered: Albuquerque Public Schools
Attn: Employee Benefits Department
6400 Uptown Blvd NE, Suite 115E

EXTERNAL REVIEW BY SUPERINTENDENT OF INSURANCE

If you are dissatisfied with the results of the internal review by Presbyterian Health Plan (PHP), the medical panel, or the Albuquerque Public Schools, you may request an external review by the New Mexico Superintendent of Insurance by filing a written request within **120 working days** for Adverse Determination review and within **20 working days** for an Administrative Grievance review from the date you receive the Benefits Advisory Committee of PHP decision. You may file your request by:

- Mail to the Office of Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation commission, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689;
- E-mail to the Office of Superintendent of Insurance, Attention: Managed Health Care Bureau at **mhcb.grievance@state.nm.us**; or
- Fax to the Office of Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, at **(505) 827-3833**
- Online by completing the NM PRC, Division of Insurance Complaint Form available at **http://www.nmprc.state.nm.us**

RETALIATORY ACTION

In accordance with the Patient Protection Act, Presbyterian Health Plan cannot, and will not, take retaliatory action against you for filing a Grievance under this health benefits plan.

MEMBER RIGHTS AND RESPONSIBILITIES

Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your health plan. Above all, your relationship with your Provider/Practitioner is essential to good health. We encourage open communication between you and your Provider/Practitioner.

MEMBER RIGHTS

All Members have a right to:

1. Be treated with courtesy, consideration, respect, and recognition of their dignity.

2. Have their privacy respected, including the privacy of medical and financial records maintained by the Claim Administrator and its healthcare Providers/Practitioners as required by law.

3. Request and obtain information concerning the Claim Administrator's policies and procedures regarding products, services, In-network Providers/Practitioners, Appeals procedures and other information about the Claim Administrator and the benefits provided.

4. Request and obtain information about any financial arrangements between the Claim Administrator and its In-network Providers/Practitioners, which might restrict treatment options or limit services offered to Members.

5. Be told the details about what is covered, maximum benefits, what is **not covered**, what drugs or medicines, and how to obtain **Prior Authorizations**, when needed.

6. Receive affordable health care, with limits on Out-of-pocket expenses.

7. Seek care from an Out-of-network Provider and be advised of their financial responsibility if they receive services from an Out-of-network Provider, or receive services without required **Prior Authorization**.

8. Be notified promptly of termination, decreases or changes in benefits, services, or the Provider/Practitioner network.

9. Participate with treating Providers/Practitioners in making decisions about their health care.

10. Clear and candid discussion of Medically Necessary treatment options, regardless of benefit coverage or cost.

11. Refuse care, treatment, or medications after the Provider/Practitioner has explained the care, treatment or other advice and possible consequences of this decision in language that the Member understands.

12. Have adequate access to qualified health professionals near where they live or work.

13. Receive information from their Provider/Practitioner, in terms that they understand, including an explanation of their complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives irrespective of the Claim Administrator's position on treatment options.

14. Have the explanation provided to next of kin, guardian, agent or surrogate if available, when the Member is unable to understand.

15. Have all explanations to the next of kin, guardian, agent or surrogate recorded in the Member's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Member.

16. Have access to services, when Medically Necessary, as determined by their primary or treating Provider/Practitioner, in consultation with the Claim Administrator, **24 hours** per day, **seven days** a week for Urgent or Emergency Health services, and for other health services as defined by this booklet.

17. Have access to translator services for Members who do not speak English as their first language, and translation services for hearing-impaired Members for communication with the Claim Administrator.

18. Receive a complete explanation of why services or benefits are denied, an opportunity to Appeal the decision to the Claim Administrator, the right to a secondary Appeal, and the right to request the Superintendent of Insurance assistance and to receive an answer within a reasonable time.

19. Make complaints or Appeals regarding the Claim Administrator or the care provided.

20. Continue an ongoing course of treatment for a period of at least **30 days** if the Member's Provider/Practitioner leaves the Provider/Practitioner network or if a new Member's Provider/Practitioner is not in the Provider/Practitioner network.

21. Make recommendations regarding the Claim Administrator's Members' rights and responsibilities policy.

MEMBER RESPONSIBILITIES

All Members must**:**

1. Review this booklet and if there are questions contact our Presbyterian Customer Service Center at **(505) 923-5600** or **1-888-275-7737** (ASK PRES) for clarification of benefits, limitations, and exclusions outlined in this booklet.

2. Provide as much as possible, information that the Claim Administrator and Providers/Practitioners need in order to provide services or care or to oversee the quality of such care or services.

3. Follow both APS and the Claim Administrator's policies, procedures, and instructions for obtaining services and care.

4. Follow the plans and instructions for care that he/she has agreed upon with his/her Provider/Practitioner. A Member may, for personal reasons, refuse to accept treatment recommended by In-network Providers/Practitioners. An In-network Provider/Practitioner may regard such refusal as incompatible with the continuance of the Provider patient relationship and as obstructing the provision of proper medical care.

5. Notify the Claim Administrator immediately of any loss or theft of his/her Identification Card.

6. Refuse to allow any other person to use his/her Identification Card.

7. Advise an In-network Provider of coverage with the Claim Administrator at the time of service. Members may be required to pay for services if they do not inform their In-network Provider of their coverage.

8. Pay all required Copayments, Deductibles, and/or Coinsurance at the time services are rendered.

9. Be responsible for the payment of all services obtained prior to the effective date of this Plan and subsequent to its termination or cancellation.

10. Promise that all information given to the Claim Administrator in Applications for enrollment, questionnaires, forms or correspondence is true and complete.

11. Understand their health problems and participate in developing mutual agreed upon treatment goals to the degree possible.

GLOSSARY OF TERMS

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

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

ADMISSION means the period of time between the date a patient enters a Hospital or other facility as an Inpatient and the date he/she is discharged as an Inpatient. The date of Admission is the date of service for the hospitalization and all related services.

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 situation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COVERED SERVICES means services or supplies specified in this SPD, including any supplements, endorsements, addenda, or riders, for which benefits are provided, subject to the terms, conditions, limitations, and exclusions of this *Summary Plan Description* and to the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide.

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

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

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

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

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

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

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

EMERGENCY MEDICAL CONDITION means a medical condition which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to your health, if pregnant the health of you or your unborn child; 2) serious impairment to the bodily functions; or 3) serious dysfunction of any bodily organ or part.

ENROLLMENT/CHANGE FORM means the form that an employee is required to complete when enrolling for APS medical plan coverage.

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

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

FAMILY MEDICAL COVERAGE means coverage for the employee, the employee's spouse, and/or the employee's Dependent children.

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

FREESTANDING HEALTH CARE FACILITIES are those that are stand alone and on its own and deliver many diagnostic and therapeutic services formerly provided only in hospitals.

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

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

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

- availability, delivery or quality of Healthcare Services;
- administrative practices of the healthcare insurer that affect the availability, delivery or quality of Healthcare Services;
- claims payment, handling or reimbursement for Healthcare Services; or
- matters pertaining to any aspect of the health benefits Plan.

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

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

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

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

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

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

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

IMMUNOSUPPRESSIVE DRUGS (Inpatient only) means drugs used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include but are not limited to: (1) preventing transplant rejection; (2) supplementing chemotherapy; (3) treating certain diseases of the immune system (i.e. "auto-immune" diseases); (4) reducing inflammation; (5) relieving certain symptoms; and (6) other times when it may be helpful to suppress the human immune response.

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

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

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

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

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

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

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

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

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

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

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

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

- it is medical in nature; and
- it is recommended by the treating Provider; and
- it is the most appropriate supply or level of service, taking into consideration:
- potential benefits;
- potential harms;
- cost, when choosing between alternative that are equally effective;
- cost-effectiveness, when compared to the alternative services or supplies;
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the Member, the treating Provider, the Hospital, or any other healthcare provider.

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

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

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

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

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

OCCUPATIONAL THERAPIST means a person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction, caused by disease, trauma, Congenital Anomaly, or prior therapeutic process, with specific tasks or goals directed activities designed to improve functional performance of the patient.

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

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

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

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

OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received in a Calendar Year that is the Member's responsibility, which is determined by the benefit level for the services received. It **does not include** expenses in excess of negotiated fees, Medicare Allowable Amounts, prescription drug Copayments, non-covered expenses, and specifically excluded expenses and services. The Out-of-network, Out-of-pocket expenses do **not** accrue toward the Out-of-pocket Maximum and vice versa.

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

PHP VIDEO VISIT means a virtual visit with a contracted MeMD provider. These visits are scheduled through the myPRES Portal.

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

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

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

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

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

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

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

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

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

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

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

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

SERVICE AREA means the entire state of New Mexico.

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

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

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

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

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

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

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

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

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

TEFRA means Federal law regarding the working aged.

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

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

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

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

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

ACCEPTANCE PAGE

The Albuquerque Public Schools agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the Albuquerque Public Schools EPO Medical Plan.

[By:] [Date:]