PRESBYTERIAN

Presbyterian Health Plan, Inc.

Summary Plan Description
City of Albuquerque
Group HMO Benefit Plan
My Care Active and My Care Family

Administered by Presbyterian Health Plan, Inc.

2021 COA HMO
MPC062122

Effective: 07/01/2021

V.2_072821

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

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

Phone:
(505) 923-7787 or
1-855-261-7737
TTY 711

Prior Authorization

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

Phone:
(505) 923-7787 or
1-855-261-7737

Claims

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

Phone:
(505) 923-7787 or
1-855-261-7737

Appeals and Grievances

Address:
Presbyterian Health Plan, Inc.
Attention: Grievance Department
P.O. Box 27489
Albuquerque, NM 87125-6267

Phone:
(505) 923-7787 or
1-855-261-7737

Fax:
(505) 923-6111

Website

www.phs.org

Table of Contents

Welcome

This *Summary Plan Description* describes your group medical benefits. The City of Albuquerque strongly believes in providing for employees' protection and welfare and is pleased to offer this Plan.

This booklet is intended to provide you with easy-to-understand general explanations of the more significant provisions of your Plan, effective July 1, 2021. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this booklet and the claims administrative procedures of our Third-Party Claim Administrator, Presbyterian Health Plan, Inc., (PHP) or if any provision is not covered or only partially covered, the terms of this benefit booklet will govern in all cases.

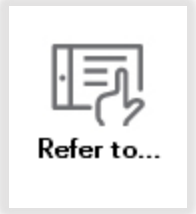
This booklet does not imply a contract of employment. The City of Albuquerque reserves the right to terminate, discontinue, alter, modify, or change this Plan or any provision of this Plan at any time.

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

Name of Plan:	City of Albuquerque, Group HMO Benefit Plan, My Care Active and My Care Family
Plan Number:	GR001365
Plan Sponsor:	City of Albuquerque
Address:	P.O. Box 1293, Albuquerque New Mexico 87103
Administrator:	Presbyterian Health Plan, Inc.
Plan Year:	July 1, 2021 to June 30, 2022

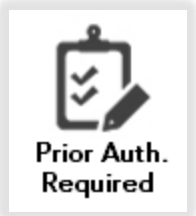
Understanding This Summary Plan Description

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.

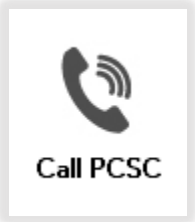
Exclusion – This "Exclusion" symbol will appear next to the description of certain Covered Benefits. The Exclusion symbol will alert you that there are some services that are excluded from the Covered Benefits and will not be paid. You should refer to the Exclusion Section when you see this symbol.



Prior Authorization Required – This "Prior Authorization Required" 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 time frame to comply with your Plan. An example of a "Timeframe" requirement is when you must enroll your newborn within 31 days of birth.

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



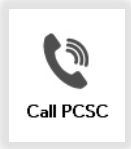
Call Presbyterian Customer Service Center – This "Call PCSC" symbol appears whenever we refer to our Presbyterian Customer Service Center or to remind you to call us for information.

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

Customer Assistance

Presbyterian Customer Service Center (PCSC)

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



Our Presbyterian Customer Service Center representatives are available Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711**. You may visit our website for useful health information and services at **www.phs.org**.

Consumer Assistance Coordinator

If you need assistance completing any of our forms, if you have special needs, or if you need assistance in protecting your rights as a Member, please call our Consumer Assistance Coordinator at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711** or visit our website at **www.phs.org**.

Written Correspondence

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

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

Introduction

The City of Albuquerque provides group healthcare coverage through the HMO Medical Plan (Plan) administered by Presbyterian Health Plan, Inc. (PHP).

You may select an In-network Primary Care Provider (PCP) to direct your healthcare needs. While not required, it is highly recommended that you select an In-network PCP. Please refer to the PHP Provider Directory or the PHP website (**www.phs.org**) when selecting your In-network PCP.

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

For additional information regarding National Health Care Practitioners/Providers please call our Presbyterian Customer Service Center prior to obtaining services Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or toll-free at **1-855-261-7737**. Users who are hearing impaired may call the TTY line at **711**.

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 Physicians, Hospitals, and other Healthcare Professionals or facilities that provide Healthcare Services.
- In-network PCPs and In-network Providers have contractual agreements with PHP 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 the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711**. It is best to call for clarification before services are rendered to ensure that proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

Member Rights and Responsibilities

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 as required by law.

3. Be advised of the Claim Administrator's policies and procedures regarding products, services, Providers, and Appeals procedures, including detailed benefit information, and Member rights and responsibilities.

4. Request and obtain information about any financial arrangements between the Claim Administrator and its Providers 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 are restricted, and how to obtain Prior Authorizations, when needed.

6. Receive affordable healthcare, 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 network.

9. Select a Primary Care Provider within the limits of the covered benefits and Provider network.

10. Change Primary Care Providers by following the rules described in this booklet.

11. Participate with Providers in decision making regarding their healthcare.

    - Clear and candid discussion of Medically Necessary treatment options, regardless of benefit coverage or cost.
    - All the rights afforded by law, rule or regulation as a patient in a licensed healthcare facility, including the right to refuse care, treatment, or medications after the Provider has explained the care, treatment or other advice in language the Member understands.

- Refuse the care of a specific Provider.
- Be informed of the potential consequences of such refusal as outlined in this booklet.

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

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

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

19. 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.

20. Have access to services, when Medically Necessary, as determined by their PCP or treating Provider, in consultation with the Claim Administrator, 24 hours per day, seven days a week for urgent or Emergency Care services, and for other health services as defined by this booklet.

21. 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.

22. Receive a complete explanation of why services or benefits are denied a chance to appeal the decision to the Claim Administrator and to receive an answer within a reasonable time.

23. Receive a Certificate of Creditable coverage when a Member's enrollment in this Plan terminates.

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

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

Member Responsibilities

All Members must:

1. Review this booklet and if there are questions contact the Presbyterian Customer Service Center at **(505) 923-7787** or toll-free at **1-855-261-7737** for clarification of benefits, limitations, and exclusions outlined in this booklet.

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

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

4. Follow the Plans and instruction for care that he/she has agreed upon with his/her Provider.

5. Follow any instructions and guidelines given by a Provider. A Member may, for personal reasons, refuse to accept treatment recommended by Providers. An In-network Provider may regard such refusal as incompatible with the continuance of the Physician-patient relationship and as obstructing the provision of proper Medical Care.

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

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

8. 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.

09. 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.

How the Plan Works

This section explains how to find Providers who are in our network (In-network), get Healthcare Services both In-network and Out-of-network, requirements you must follow when getting care and how to receive Covered Benefits under this SPD.

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

Preventive benefits, as defined by the Affordable Care Act (ACA) are not subject to the deductible. This means you can access this benefit and the plan will pay even if you have not met the individual or family deductible. Please see the "Clinical Preventive Services" benefit on your Summary of Benefits and Coverage for further information. Prescription Drugs are not part of the Clinical Preventive Services benefit and thus, are subject to the deductible and Coinsurance listed in the Summary of Benefits and Coverage.

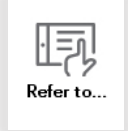
We require that:

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

All of your Healthcare Services are provided by In-network Contract Providers in our Service Area, except for Urgent and Emergency Healthcare Services situations. Please refer to the Benefits Section Accidental Injury/Urgent Care/Emergency Healthcare Services/ Observations/Trauma Services.

You select a PCP from the Provider Directory to coordinate all of your care.

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



To receive care under our plan, you must select an In-network PCP to manage your healthcare needs. Your PCP will be able to meet most of these needs. A list of Providers who serve as In-network PCPs may be found in the Provider, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). As a Member of the health plan,

you may choose as your PCP any doctor or Nurse Practitioner on the list. If you do not designate a PCP on your enrollment form, we will select one for you.

Provider Directory

You will find our In-network Providers close to where you live and work across the State. The Provider Directory is available on our website at **https://www.phs.org/Pages/find-a-doctor.aspx**. If you need additional information about a Provider, you may call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711**.

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

Obtaining Healthcare

How to obtain Primary Care Services.

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

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

You may want to ask relatives or friends if they have a PCP they would recommend. A provider may not be a PCP for himself/herself or immediate family members. You may change your PCP by contacting customer service. The requested change will be effective the next business day after you call customer service.

Unique Services Reimbursement Program

The Unique Services Reimbursement Program offers individuals enrolled on the Active plan reimbursement for specialized services as described below and in your Summary of Benefits and Coverage. These services do not have to be Medically Necessary services and use of these services is at the Member's sole discretion. However, services indicated with an "*" must be recommended by a Provider to treat a specific medical condition. Use of network Providers and Prior Authorization is not required. PHP makes no representation or warranty as to their efficacy. PHP does not credential or review, and makes no representations or warranties regarding qualification, licensing, assets or insurance of any entities utilized for these services.

Those enrolled on the Active plan will receive up to the dollar amount listed on your Summary of Benefits and Coverage for the following services:

- Gym memberships fee.*
- Weight loss program membership fees.*
- Routine vision care – eye refractions, glasses, contact lenses.*
- Smoking cessation services (above and beyond those Covered by the benefit plan)
- Vitamins* and herbal supplements.*
- Birth control pills prescribed by a Provider.
- Sterilization services.
- LASIK surgery.
- Dental treatments (cosmetic services such as teeth whitening are not reimbursable.)*
- Ambulance Copayments.
- Copayments for x-rays.
- Preventive Care Copayments (must be associated with a Presbyterian Health Plan paid preventive claims.)*
- Scan (x-rays, magnetic Resonance Imaging (MRIs), etc.)

*If recommended by a Provider to treat a specific medical condition. A note or prescription from the Provider and the Unique Services Reimbursement Program Claim Form must be submitted.

Reimbursements for these services are based on a Calendar Contract Year. All Members of the enrolled employee's family that are Covered on this plan are eligible for these reimbursements. The Unique Services Reimbursement amount listed on your Summary of Benefits and Coverage is per family not per Member. Request for reimbursement must be submitted within one year from the date of service.

How to receive reimbursement for these services

To receive reimbursement for the services listed above, provide your receipt along with the Unique Services Reimbursement Program Claim Form to:

Presbyterian Health Plan
Attention: Claims-Unique Services Reimbursements
PO Box 27489 Albuquerque, NM 87125-7489

For services to be eligible for reimbursement, the attached receipt must be from a business with a valid business license for that type of service. Contact customer service at **(505) 923-7787** or **1-855-261-7737**. (**TTY** users may call **711**) to obtain the Unique Services Reimbursement Program Claim Form.

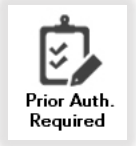
Women's Healthcare Provider/Practitioner

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

Specialist Care

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

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



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

Obtaining Care after Normal Provider Office Hours

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

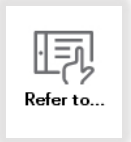
If Emergency Healthcare Services are needed, you should call 911, or seek treatment at an Emergency Room. If in need of Urgent Care, you may seek treatment at an Urgent Care Center that is available and open for business. Please note that some Urgent Care Centers are not open after 8 p.m. In such circumstances,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

In-network Providers

In-network Providers, including Primary Care Providers, specialists, facilitates and ancillary Healthcare Professionals, must be utilized, except in cases of an emergency. Members are

responsible for paying the appropriate Cost Sharing (Deductible, Coinsurance and/or Copayments) directly to the In-network Provider at the time services are rendered when such amounts are clearly specified by the Provider.

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



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

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

Out-of-network Providers

Out-of-network Providers are healthcare Providers, including nonmedical facilities, who have not entered into an agreement with us to provide Healthcare Services to PHP Members.

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

Services provided by an Out-of-network Provider, except emergency services, require that your PCP request and obtain written approval (authorization) from our Medical Director **before** services are rendered. Otherwise, you will be responsible for payment. Please refer to the Prior Authorization section for more information on Prior Authorization requirements.

If the services of an Out-of-network Provider are required, your In-network Provider must request and obtain Prior Authorization from our Medical Director **before** services are performed, otherwise, we will **not cover** the services and you will be responsible for payment.

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

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

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

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

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

Restrictions on Services Received Outside of the PHP Service Area

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

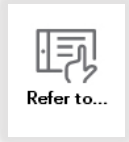
You will not have any claims to file or papers to fill out in order to be reimbursed for medical services obtained from In-network Providers and an out-of-state Network Provider/Private Healthcare Systems NP/PHCS Providers. Your In-network Provider or out-of-state MP/PHCS Provider will bill us directly. Most doctor visits and Hospital Admissions however, do require Copayment at the time of service. The amount of your Copayment for each service can be found in the *Summary of Benefits*.

Cost Sharing Your Out-of-Pocket Costs

Many Healthcare Services you receive from In-network and Out-of-network Providers require some payment from you. We refer to these payments as Cost Sharing. These are your Out-of-pocket costs and may be Deductibles, Coinsurance and /or Copayment amounts.

Annual Contract Year Deductible

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



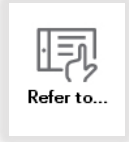
For single Coverage, the Annual Calendar Year Deductible requirement is fulfilled when one Member meets the individual Deductible listed in the Summary of Benefits and Coverage. For double or family coverage, The Annual Contract Year Deductible can be satisfied by any combination of the family members. No one Member can contribute more than the stated Member amount. Once the Member meets their individual amount, their Annual Contract Year Deductible is considered met. The Annual Contract Year family and individual Deductible amounts are listed in the Summary of Benefits and Coverage.

Coinsurance

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

Annual Out-of-pocket Maximum

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



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

For double or family Coverage, with two or more enrolled Members, the entire family Out-of-pocket Maximum must be met before benefits will be paid at 100 percent. 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 percent for that Member

who has met the individual Out-of-pocket Maximum. The family and individual Out-of-pocket Maximum amounts are listed in the Summary of Benefits and Coverage.

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

To inquire about the status of your specific Annual Out-of-pocket Maximum, you may call customer service Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711**.

Office Visit Copayment

If your Plan has an office visit Copayment, this is the amount of Cost Sharing you must pay each time you have an office visit with an In-network Provider. This Copayment is for the office visit only, unless otherwise indicated on the Summary of Benefits and Coverage. All other services provided during the visit are subject to other Cost Sharing (Deductible and Coinsurance). Refer to your Summary of Benefits and Coverage for all Cost-Sharing Copayment, Deductible and Coinsurance amounts.

Utilization Management and Quality

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

Technology Assessment Committee

We have a process to continuously evaluate evolving medical technologies, which include medical procedures, drugs and devices. In-network Providers from our Provider network and the community along with other clinical staff are responsible for this process and are known as the Technology Assessment Committee. The Technology Assessment Committee evaluates new technologies and/or new applications of existing technologies, determines the value of the new technology, and recommends whether the technology should be a specified Covered Benefit of your Plan. Factors to be considered include safety, comparison to existing drugs, procedures and technology, cost and effectiveness of the new technology, and clinical skills and training of those proposing to provide the new technology.

Transition of Care/Continuity

If you are in an ongoing course of treatment with an In-network 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.

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

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

Fraud and Abuse

The PHP Special Investigative Unit (SIU) is responsible for the detection, investigation and reporting of potential fraud and abuse activity. We are required to cooperate with regulatory and law enforcement agencies in reporting any activity that appears to be suspicious in nature. According to the law, any information that we have concerning such matters must be turned over to the appropriate governmental agencies.

How to report Suspicious Activity to PHP

You can contact the SIU 24 hours a day by leaving a telephone message on the confidential fraud hotline. We will treat any information that you provide with strict confidentiality. When reporting suspected health insurance fraud, you may remain anonymous:

Hotline in Albuquerque:	**(505) 923-5959**
Toll-free Hotline within the state of New Mexico:	**1-800-239-3147**
Email:	**PHPFraud@phs.og**
File Online:	**https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/default.aspx**
PHP Mailing Address:	PHP Special Investigative Unit (SIU) PO Box 27489 Albuquerque, NM 87125-7489

When reporting suspected fraud, please remember to include the names of all applicable parties involved. Specify which person you believe is committing the fraud, identify the dates of service or issues in question and describe in detail why you believe a fraudulent act may have occurred. If possible, please include your name and telephone number so we may contact you if we have any questions during our investigation.

What is the definition of Fraud and Abuse?

Fraud is defined as an intentional deception or misrepresentation with the knowledge that the deception could result in some unauthorized benefit to a person or an entity.

Abuse is defined as incidents or practices that are inconsistent with accepted, sound business, fiscal or medical administrative practices.

While true fraud involves only a small percentage of individuals, the costs associated with it are high. Suspicious activity exists when there is a reasonable belief that fraud or abuse may have occurred.

Examples of Provider Fraud:

- Billing for services not rendered.
- Altering medical record.
- Use of un-licensed staff.
- Drug diversion.
- Kickbacks and bribery.

Examples of Member Fraud:

- Falsification of information.
- Forging or selling Prescription Drugs.
- Using transportation benefit for non-medical related business.
- Adding or maintaining an ineligible Dependent to the plan.
- "Loaning" or using another person's insurance card.

Examples of Employer Group Fraud:

- Providing false employer or group membership information to secure healthcare coverage.
- Falsification of information.
- Misrepresenting who is actually eligible for coverage by representing them as an employee of the group.

Do I run a risk reporting fraud?

No. Any person reporting insurance fraud in good faith is immune from civil liability. That means that no one can take any adverse action against you for reporting what you reasonably believe to be insurance fraud. A court must award attorney's fees and costs to any person winning a lawsuit arising out of such a report.

Anti-Fraud Contacts

Office of Superintendent of Insurance:	
Address:	Office of Superintendent of Insurance Insurance Fraud Bureau P.O. Box 1689 Santa Fe, NM 87504-1689
Main Number:	(855) 4-ASK-OSI (427-5674)
Toll-free Number:	1-877-807-4010
Email (Bureau):	**stopfraud@state.nm.us**

New Mexico Medical Assistance Division for Medicaid Fraud:	
Toll-free Number:	1-888-997-2583
Email:	**NMMedicaidFraud@state.nm.us**

Centers for Medicare and Medicaid Services (CMS):	
Office of the Inspector General (OIG) National Fraud Hotline Number:	1-800-447-8477
Email:	**http://oig.hhs.gov/fraud/report-fraud/index.asp**

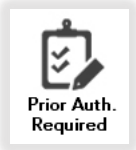
Note: PHP provides the above information because they may be of interest or useful to you. PHP does not own, control, or influence these sites, and is not responsible for their content.

Advance Directives

An advance directive is a legal document about your healthcare decisions. It is only used when you are unable to speak for yourself and includes information about the person you want to make healthcare decisions on your behalf regarding medical service(s) you do and do not want. These are documents you complete in advance and can share with your provider or person who will speak on your behalf. Sharing your advance directives with your healthcare team helps make your wishes clear.

Prior Authorization

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



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

What is Prior Authorization?

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

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

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

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

Prior Authorization Is Required

Certain services and supplies are Covered Benefits only if we Authorize them prior to the actual service or delivery of supplies. This does not apply to benefits mandated by law. Authorization means our decision that a Healthcare Service requested by your Provider or by you has been reviewed and, based upon information available, meets our requirements for Coverage and Medical Necessity, and the requested Healthcare Service is therefore approved. If a required Prior Authorization is not obtained for services by Out-of-network

Providers, except for emergency care, the Member may be responsible for the resulting charges. Services provided beyond the scope of the Prior Authorization may not be Covered.

Prior Authorization When In-network

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

Prior Authorization When Out-of-network

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

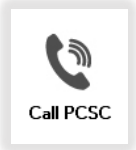
If required medical services are not available from In-network Providers, the PCP must request Prior Authorization and obtain written Authorization from our Medical Director before you may receive Out-of-network services. Services of an Out-of-network Provider may not be Covered unless this Authorization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

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

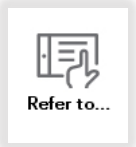
- Availability – The In-network Provider is not reasonably available to see you in a timely fashion as dictated by the clinical situation.
- Competency – The In-network Provider does not have the necessary training or expertise required to render the service or treatment.
- Geography – The In-network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

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

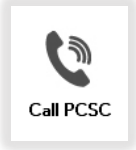
Prior Authorization is required for Inpatient admissions, and all services related to the inpatient admission before you receive these services In-network or Out-of-network from any Provider, Healthcare Facility or other Healthcare Professional. Our network of Providers will obtain Prior Authorization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



If you want to know more about Prior Authorization, please call our Presbyterian Customer Service Center, as soon as possible before services are provided, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737. TTY** users may call **711**. You may also visit our website at **www.phs.org**.



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



Note: Due to the ever-changing nature of healthcare services, updates are made to the list from time-to-time throughout the year. For access to the most current list, you may contact our Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711**. You may also visit our website at **www.phs.org**.

- Acute Medical Detoxification (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the Covered Benefits section).
- All Hospital admissions, Inpatient non-emergent (listed under Hospital Services-Inpatient in the Covered Benefits section).
- Autism Spectrum Disorder.
- Bariatric Surgery.
- Bone Growth Stimulator.
- Clinical Trials (Investigational/Experimental) (listed under Clinical Trials 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 Cover Benefits section).
- Durable Medical Equipment (listed under Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids in the Covered Benefits section).
- 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).
- Hyperbaric Oxygen (listed under Hyperbaric Oxygen Therapy in the Covered Benefits section).
- Injectable Drugs, (includes Specialty Medications and Medical Drugs) (listed under Preventive Health Services for Women and also Provider Services in the Covered Benefits section).

- Magnetic Resonance Imaging (MRI) in an outpatient setting (listed under Diagnostic and Imaging Services in the Covered Benefits section).
- Medical Drugs.
- 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.
- Prescription Drugs/Medications.
- Prosthetic Devices (listed under Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids and also Women's Healthcare in the Covered Benefits section).
- Proton Beam Irradiation.
- Reconstructive and potentially cosmetic procedures (listed under Reconstructive Surgery and also Women's Healthcare Services in the Covered Benefits section).
- Selected Surgical/Diagnostic procedures.
  - Ankle Subtalar Arthroereisis.
  - Blepharoplasty/Brow Ptosis Surgery.
  - Breast implant removal and/or replacement and capsulectomy.
  - Breast Reconstruction following Mastectomy.
  - Breast reduction for gynecomastia.
  - Breast reduction mammoplasty for symptomatic breast hypertrophy.
  - 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.
- Sleep disorder studies in an outpatient setting.
- 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).
- Spinal Muscular Atrophy.
- Substance Use Disorder services, Inpatient (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the Covered Benefits section).
- Transgender services with a diagnosis of gender dysphoria.
- Temporo/Craniomandibular Joint Disorders (TMJ/CMJ) (listed under Dental Services (Limited) in the Covered Benefits section).
- Transplant Services (listed under Transplants in the Covered Benefits section).
- Virtual Colonoscopy (listed under Clinical Preventive Health Services in the Covered Benefits section).
- Wireless Capsule Endoscopy.

Authorizing Inpatient Hospital Admission following an Emergency

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

Obtaining Prior Authorization does not guarantee your eligibility for coverage, that benefits will be paid or that you will receive the highest level of benefits.

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

Prior Authorization Decisions – Non-Emergency

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

Prior Authorization Decision – Expedited (Accelerated)

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

Prior Authorization Review – Initial Adverse Determination

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

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

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

Please see the **Complaints, Grievances and Appeals section** for information regarding how to request an internal review of any Adverse Determinations that we make.

Covered Benefits

Benefits are subject to the Copayments and Coinsurance listed in the *Summary of Benefits and Coverage*. Please refer to page the Limitations and Exclusions Sections 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 PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See the "Grievance Procedure" section.

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

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

Urgent Care

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

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

Emergency Healthcare Services

This Agreement covers acute Emergency Healthcare Services 24 hours per day, seven days per week, when those services are needed immediately to prevent jeopardy to your health. You should seek medical treatment from an In-network Provider or facility whenever possible.

If you cannot reasonably access an In-network facility, we will arrange to Cover the care at an out-of-network facility at the in-network benefit level. Whether out-of-network Emergency Healthcare Service is appropriate will be determined by the Reasonable/Prudent Layperson standard discussed below.

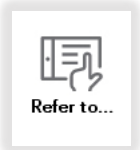
In determining whether you acted as a Reasonable/Prudent Layperson we will consider the following factors:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment
- The presenting symptoms
- Any circumstances that prevented you from using our established procedures for obtaining Emergency Healthcare Services

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

We will provide reimbursement when you, acting in good faith, obtain Emergency Healthcare Services for what reasonably appears to you, acting as a Reasonable/Prudent Layperson, to be an acute condition that requires immediate medical attention, even if your condition is later determined to not be an emergency. Jeopardy to the person's health.

Prior Authorization is not required for Emergency Healthcare Services. If you are admitted as an Inpatient to the Hospital, you or your Provider needs to notify us as soon as possible so we can review your Hospital stay. We will not deny a claim for Emergency Healthcare Services when the Member was referred to the Emergency Room by his or her PCP or by our representative.



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

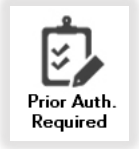
For Emergency Healthcare Services out-of-network or outside of our New Mexico Service Area, you may seek Emergency Healthcare Services from the nearest appropriate facility where Emergency Healthcare Services can be rendered. These services will be Covered as In-network services. Non-emergent follow-up care outside of New Mexico is not Covered for your convenience or preference. You are responsible for any such charges that we do not Authorize the Healthcare Services. Follow-up care from an Out-of-network Provider requires our Prior Authorization.

Observation Services

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

- Evaluate an Outpatient's condition.

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



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

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

Ambulance Services

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

The following types of Ambulance Services are Covered:

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

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

- Within New Mexico, to the nearest In-network facility where Emergency Healthcare Services and treatment can be rendered, or an Out-of-network facility if an In-network facility is not reasonably accessible. Such services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside of New Mexico, to the nearest appropriate facility where Emergency Healthcare Services and treatment can be rendered. Such services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life sustaining equipment and personnel.
- We will not pay more for air Ambulance Services than we would have paid for ground Ambulance Services over the same distance unless your condition renders the utilization of such ground transportation services medically inappropriate.

- In determining whether you acted in good faith as a Reasonable/Prudent Layperson when obtaining Emergency Ambulance Services, we will take the following factors into consideration:
- Whether you required Emergency Healthcare Services, as defined above
    - The presenting symptoms
    - Whether a Reasonable/Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health.
    - Whether you were advised to seek an Ambulance Service by your Provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Agreement.
    - Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

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

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

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

Coverage for High-Risk Ambulance Services is limited to:

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

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

- Medically Necessary.
- Prescribed by your Provider.

- Provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

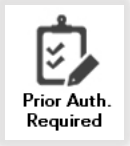
Baby Benefits (Presbyterian)

As a Presbyterian Health Plan Member through the City of Albuquerque, you are eligible for the Presbyterian Health Plan Baby Benefits program. This program is focused on the importance of prenatal and postpartum care. It rewards you for visiting your Provider for all the prenatal and postpartum visits recommended by the program. Please see the Presbyterian Baby Benefits flyer attached to the back of this Summary Plan Description.

Bariatric Surgery

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

Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m^2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions; and Prior Authorization is required for both In-network and Out-of-network facilities and services must be performed at a facility that is designated by Presbyterian Health Plan, Inc., and as a bariatric surgery Center of Excellence by Centers for Medicare and Medicaid Services (CMS). Out-of-network Benefits may apply depending upon the bariatric surgical Center of Excellence chosen.



Clinical Trials

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

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

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

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

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

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

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

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

Certified Hospice Care

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

Benefits for Inpatient and in-home Hospice services are Covered if you are terminally ill. Services must be provided by an approved Hospice program during a Hospice benefit period and will not be Covered to the extent that they duplicate other Covered Services available to you. Benefits that are provided for by a Hospice or other facility require Prior Authorization.
The Hospice benefit period is defined as follows:

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

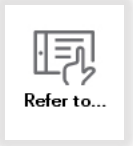
The following services are Covered:

- Inpatient Hospice care
- Provider visits by Certified Hospice Providers
- Home Health Care Services by approved home health care personnel
- Physical therapy
- Medical supplies
- Prescription Drugs and Medication for the pain and discomfort specifically related to the terminal illness
- Medical transportation
- Respite care (care that provides a relief for the caregiver) for a period not to exceed five continuous days for every 60 days of Hospice care. No more than two respite care stays will be available during a Hospice benefit period.

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

Clinical Preventive Health Services

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



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

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

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

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

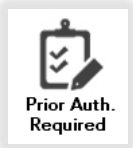
Adult Screening and Counseling Services

Screenings and counseling services will provide coverage for evidence-based services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force for individuals in certain age groups or based on risk factors. These guidelines can be found at **https://www.phs.org/tools-resources/patient/Pages/preventive-care-guidelines.aspx**.

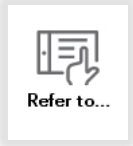
Key screenings include:

- Preventive physical examinations.
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam.
- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level.
- Periodic stool examination for the presence of blood for adults 45 years of age or older
- Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:

    - Fecal occult blood testing (FOBT).
    - Flexible Sigmoidoscopy.
    - Colonoscopy, including anesthesia services.
    - Virtual Colonoscopy - Requires Prior Authorization.
    - Double contrast barium enema.



- Smoking Cessation Program - Refer to **Smoking Cessation Counseling/Program** in this section.
- Screening to determine the need for vision and hearing correction.
- Periodic glaucoma eye test.



- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, human immunodeficiency virus (HIV) and sexually transmitted infections, as well as counseling for substance use and tobacco use, healthy eating and other common health concerns.
- Health education and consultation from Providers to discuss lifestyle behaviors that promote health and well-being.

Routine Immunizations

Routine Immunization includes Coverage for Adult and Child Immunizations (shots or vaccines), in accordance with the recommendations of the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

Childhood Preventive Health Services

Childhood Preventive Health Services includes Coverage for well-child care in accordance with the recommendations of the United States Preventive Services Task Force, and the American Academy of Pediatrics/Bright Futures Guidelines.

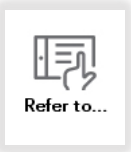
The Health Resources and Services Administration (HRSA) Bright Futures Program aims to improve health outcomes for the infants, children, and adolescents by increasing the quality of primary and preventive care through age-specific recommendations are found here: **https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**.

Preventive Health Services for Women

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

- Well-woman visits to include adult and female-specific screenings and preventive benefits.
- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.

    - Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. Please contact Express Scripts at **1-877-860-9256**.
- Domestic and interpersonal violence screening and counseling for all women.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Infections.
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility.
- Sexually Transmitted Infections (STI) counseling for sexually active women.
- Sterilization services for women only. Other services, performed during the procedure, are subject to Deductible and Coinsurance as outlined in your *Summary of Benefits and Coverage*.



You can obtain additional information about Women's Preventive Services Recommendations and Guidelines **at https://www.phs.org/tools-resources/patient/Pages/preventive-care-guidelines.aspx#Adult-Guidelines**.

Complementary Therapies

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

Acupuncture

Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by your Provider.

It is recommended that Acupuncture be part of a coordinated plan of care approved by your Provider.

Acupuncture services are limited to a Contract Year maximum benefit unless for rehabilitative or habilitative purposes.

Chiropractic Services

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

- The Provider determines in advance that Chiropractic treatment can be expected to result in significant improvement in your condition within a period of two months.

- Chiropractic treatment is specifically **limited** to treatment by means of manual manipulation (i.e., by use of hands, and other methods of treatment approved by us including, but not limited to, ultrasound therapy).
- Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. We do not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment.
- Chiropractic X-rays are only Covered when performed by a Chiropractor, unless clinically relevant X-rays already exist.

Chiropractic services are **limited** to a Contract Year maximum benefits unless for rehabilitative or habilitative purposes.

Biofeedback

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

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.

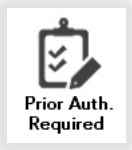
Dental Services (Limited)

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

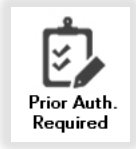
Dental benefits will be provided in connection with the following conditions when deemed Medically Necessary except in an emergency situation as described in the **Accidental Injury (trauma), Urgent Care, Emergency Healthcare Services and Observation Services** section. Covered Services are as follows:

- Accidental Injury to sound natural teeth, jawbones or surrounding tissue. Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury and **will not** be Covered.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.

- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Hospitalization, day surgery, Outpatient and/or anesthesia for non-Covered dental services, are Covered, if provided in a Hospital or ambulatory surgical center for dental surgery, with our approval of a Prior Authorization request. Plan benefits for these services include coverage:



    - For Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
    - For Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
    - For Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
    - For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
    - For other procedures for which Hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- Temporo/Craniomandibular Joint Disorders (TMJ/CMJ).
    - The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of orthotic devices (TMJ splints) are subject to the same conditions, limitations, and require Prior Authorization as they apply to treatment of any other joint in the body.



Diabetes Services

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

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 approval, and are the medically accepted standards for diabetes treatment, supplies and education.

Diabetes Education (Limited)

The following benefits are available when received from a Provider who is approved to provide diabetes education:

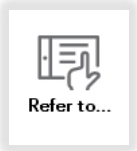
- Medically Necessary visits upon the diagnosis of diabetes.
- Visits following a Provider diagnosis that represents a significant change in condition or symptoms requiring changes in the patient's self-management.
- Visits when re-education or refresher training is prescribed by a healthcare Provider with prescribing authority.
- Telephonic visits with a Certified Diabetes Educator (CDE).
- Medical nutrition therapy related to diabetes management.

Approved diabetes educators must be part of our In-network Providers who are registered, certified or licensed Healthcare Professionals with recent education in diabetes management.

Diabetes Supplies and Services

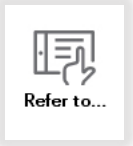
The following equipment, supplies, appliances, and services are Covered when prescribed by your Provider and when obtained through the designated network Provider: These items require the use of approved brands and must be purchased at an In-network pharmacy, Preferred vendor or Preferred Durable Medical Equipment (DME) supplier. Please contact customer service from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737** (**TTY** users may call **711**). You may also visit our website at **www.phs.org** for further information.

- Insulin pumps when Medically Necessary, prescribed by an In-network endocrinologist.
- Specialized monitors/meters for the legally blind.
- Medically Necessary Covered Podiatric appliances for prevention of feet complications associated with diabetes. Refer to the **Durable Medical Equipment Benefits** section.
- Preferred Prescriptive diabetic oral agents for controlling blood sugar levels.
- Preferred Insulin - Refer to your *Formulary* for preferred insulin – please contact Express Scripts at **1-877-860-9256** for Preferred monitors.
- Syringes – Please contact Express Scripts at **1-877-860-9256**.
- Injection aids, including those adaptable to meet the needs of the legally blind.
- Preferred blood glucose monitors/meters – Please contact Express Scripts at
- **1-877-860-9256** for Preferred monitors.
- Preferred test strips for blood glucose monitors – Please contact Express Scripts at
- **1-877-860-9256** for Preferred Test strips.
- Visual reading urine ketone strips – Please contact Express Scripts at **1-877-860-9256**.



- Preferred Continuous Glucose Monitoring (CGM) including system, sensor, and transmitter – please contact Express Scripts at **1-877-860-9256**.
- Insulin pumps – please contact Express Scripts at **1-877-860-9256**.

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



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

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

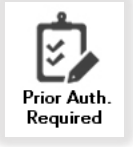
- Computerized Axial Tomography (CAT) scans – requires Prior Authorization
- Magnetic Resonance Angiogram (MRA) tests, Magnetic Resonance Imaging (MRI) tests – require Prior Authorization
- Sleep disorder studies in home or facility
- Bone density studies
- Clinical laboratory tests
- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiology/X-ray services

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

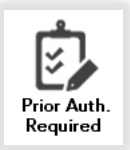
This benefit has one or more exclusions as specified in the Exclusions section.

Durable Medical Equipment

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



Orthotic Appliances

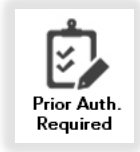


Orthotic appliances include braces and other external devices used to correct a body function including clubfoot deformity. Orthotic appliances require Prior Authorization.

Orthotic appliances are subject to the following limitations:

- Foot orthotics or shoe appliances are not Covered, except for our Members with diabetic neuropathy or another significant neuropathy.
- Custom fabricated knee-ankle foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for our Members in accordance with nationally recognized guidelines. Orthotic appliances are limited to Contract Year maximum. Refer to your Summary of Benefits and Coverage for this maximum.

Prosthetic Devices

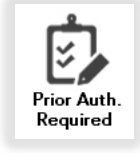


Prosthetic devices are artificial devices, which replace or augment a missing or impaired part of the body. The purchase, fitting and necessary adjustments of prosthetic devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are Covered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

Examples of prosthetic devices include, but are not limited to:

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

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



Repair and replacement of Durable Medical Equipment, prosthetics and orthotic devices requires Prior Authorization, except when provided for diabetes-related services. All diabetes-related services are provided in accordance with State law. Please refer to the Diabetes Services section.

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

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

Surgical Dressing

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

Gradient compression stockings are Covered for:

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

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

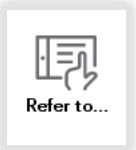
Eyeglasses and Contact Lenses (Limited)

The following will only be Covered:

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

Hearing Aids

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



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

Family, Infant and Toddler Program

Coverage for children, from birth up to age three under the Family, Infant and Toddler Program (FIT) Program administered by the Department of Health, provided eligibility criteria are met, is provided for Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel in accordance with State law. Benefits

used under this Section will not be applied to your Annual Contract Year Deductible or Annual Out-of-pocket Maximum.

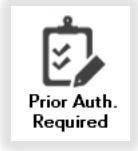
Genetic Inborn Errors of Metabolism Disorders

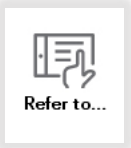
This benefit has one or more exclusions as specified in the Exclusions section.

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

Covered Services include:

- Nutritional and medical assessment.
- Clinical services.
- Biochemical analysis.
- Medical supplies.
- Prescription Drugs/Medications – Please contact Express Scripts at **1-877-860-9256**.
- Corrective lenses for conditions related to Genetic IEM.
- Nutritional management.
- Special Medical Foods are dietary items that are specially processed and prepared to use in the treatment of Genetic IEM to compensate for the metabolic abnormality and to maintain adequate nutritional status when we approve the Prior Authorization request and when provided under the on-going direction of a qualified and licensed healthcare Provider team.





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

Gym Membership

If your plan includes the Gym Membership Benefit, as a Presbyterian Health Plan Member, you and your enrolled dependents (age 18 and older) have access to a designated list of participating national, regional and local fitness, recreation, and community centers.

Participating fitness facilities are subject to change. Presbyterian Health Plan is not responsible for ensuring certain facilities remain part of the participating network.

Habilitative Services

Autism Spectrum Disorder

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

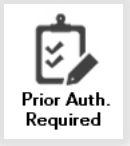
- Diagnosis for the presence of Autism Spectrum Disorder when performed during a Well-child or Well-baby screening; and/or
- Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis to develop, maintain, restore and maximize the functioning of the individual,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

Habilitative service requires Prior Authorization and your Provider's approved plan of care. The Health Services Department will review the treatment plans in accordance with state mandated benefits.

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

Home Health Care Services/Home Intravenous Services and Supplies

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



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

Any Provider's prescription and Prior Authorization must be renewed at the end of each 60-day period. We will not impose a limitation on the number of related hours per visit.

Home Health Care Services shall include Medically Necessary skilled intermittent Healthcare Services provided by a registered nurse or a licensed practical nurse; physical, occupational, and/or respiratory therapist; and/or speech pathologist. Intermittent Home Health aide services are only Covered when part of an approved plan of care which includes skilled services.

Such services may include collection of specimens to be submitted to an approved laboratory facility for analysis.

Medical equipment, Prescription Drugs and Medications, laboratory services and supplies deemed Medically Necessary by a Provider for the provision of health services in the home, except Durable Medical Equipment, will be Covered.

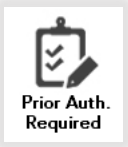
The following Home Health Care Services will be Covered when we approve a Prior Authorization request:

- Home Health Care or home intravenous services as an alternative to Hospitalization, as determined by your Provider
- Total parenteral and enteral nutrition as the sole source of nutrition
- Medical Drugs: (Medications obtained through the medical benefit): A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the member's home, provider's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a Prior Authorization, and some must be obtained through the specialty network. Please contact Express Scripts at **1-877-860-9256**.

Hospital Services Inpatient

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

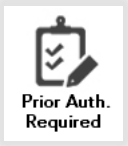
Inpatient means you have been admitted by a healthcare Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services are acute care services provided when you are a registered bed patient and there is a room and board charge. Admissions are considered Inpatient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



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

Inpatient services provided by Out-of-network Providers or facilities are not Covered except as provided in How This Plan Works, Accidental Injury/Urgent /Emergency and Termination and Continuation sections of this SPD. Inpatient Hospital benefits also include acute medical detoxification.

Hyperbaric Oxygen Therapy



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

Infertility Services

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

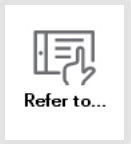
- Surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is not the result of a surgical sterilization; and
- Replacement of deficient, naturally occurring hormones if there is documented evidence of a deficiency of the hormone being replaced.

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, gamete intrafallopian transfer, zygote intrafallopian transfer, all drugs, hormonal manipulation, or embryo transfer **is not** a covered benefit. Any artificial conception method not specifically listed is also **excluded**.

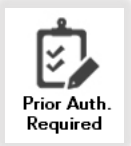
Mental Health Services and Alcoholism and Substance Use Disorder Services

Mental Health Services



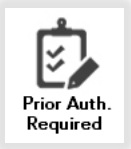
Some mental health services require Prior Authorization. The In-network Behavioral Health Providers will be responsible for obtaining Prior Authorization, when required. For Out-of-network Services, Members need to contact our Behavioral Health Department to obtain Prior Authorization when required, except when requesting emergency services. Mental health services that require Prior Authorization are inpatient hospitalization, partial hospitalization, and residential treatment. Please refer to the Prior Authorization section for services that require Prior Authorization. Contact the Behavioral Health Department directly at **(505) 923-5470** or **1-800-453-4347**.

Partial Hospitalization can be substituted for the Inpatient mental health services when our Behavioral Health Department approves the Prior Authorization request. Partial Hospitalization is a non-residential, Hospital-based day program that includes various daily and weekly therapies. Acute Medical detoxification benefits are Covered under Inpatient and Outpatient medical services found in the Benefits section. Some services require Prior Authorization.

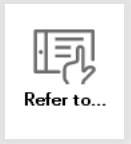


Alcohol and Substance Use Disorder Services

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



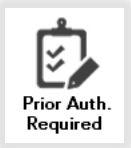
For Out-of-network Services, Members need to contact our Behavioral Health Department in order to obtain Prior Authorization, when required. Please refer to the Prior Authorization section. In all cases, treatment must be Medically Necessary in order to be Covered.



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

Nutritional Support and Supplements

Nutritional supplements for prenatal care when prescribed by a Provider are Covered for pregnant women.

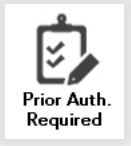


Nutritional supplements that require a prescription to be dispensed are Covered when prescribed by a Provider and when Medically Necessary to replace a specific documented deficiency. Prior Authorization is required.

Nutritional supplements administered by injection at the Provider's office are Covered when Medically Necessary.

Enteral formulas or products, as nutritional support, are Covered only when prescribed by an In-network Provider and administered by enteral tube feedings.

Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is Covered when ordered by a Provider.



Special Medical Foods as listed as Covered benefits in the Genetic Inborn Errors of Metabolism Benefit of this section. Prior Authorization is required.

Outpatient Medical Services

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

Outpatient Medical services include reasonable Hospital services provided on an ambulatory (Outpatient) basis and those diagnostic and treatment procedures that are prescribed by your attending Provider. Refer to the Prior Authorization section for services that require Prior Authorization.

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

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

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

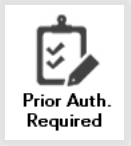
- Covered under the Unique Services Reimbursement Program (Active Plan). Refer to How the Plan Works in this Agreement.
- Dialysis.
- Diagnostic Services – refer to the Diagnostic Services section.
- Acute medical detoxification: Medically Necessary Services for Substance Use Disorder detoxification.
- Medical Drugs (Medications obtained through the medical benefit).
- A Medical Drug is any drug administered by a Healthcare Professional and is typically given in the member's home, provider's office, freestanding (ambulatory) infusion suite, or Outpatient facility. Medical Drugs may require a Prior Authorization and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require Prior Authorization and what drugs are mandated to our Specialty network, please contact Express Scripts at **1-877-860-9256**.
- Observation following Outpatient Services.
- Sleep disorder studies, in home or outpatient facility.
- Surgery.
- Therapeutic and support care services, supplies, appliances, and therapies.
- Wound care.

Provider Services

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

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

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

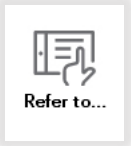


Some Provider services require Prior Authorization. Refer to the Prior Authorization section for Prior Authorization requirements. This Benefit includes, but not limited to, consultation and Healthcare Services and supplies provided by your Provider as shown below:

- Office visits provided by a qualified Provider.
- PHP Video Visits provided online between a designated Provider and patient about non-urgent healthcare matters. PHP Video Visits utilize MeMD's nationwide network of Providers.
- 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.
- Online visits are an online medical interview followed by a response from a Presbyterian Medical Group Provider.
- Outpatient surgery and Inpatient surgery including necessary anesthesia services. Hypnotherapy is Covered as part of anesthesia preparation.
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care.
- Allergy services, including testing and serum.
- Sterilization procedures.
- Student Health Centers: Dependent students attending school either in New Mexico or outside New Mexico may receive care through their PCP or at the Student Health Center. A Prior Authorization is not needed prior to receiving care from the Student Health Center. Services provided outside of the Student Health Center are limited to Medically Necessary Covered services for the initial care or treatment of an Emergency Healthcare Service or Urgent Care situation.

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

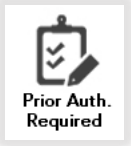
Prescription Drugs/Medications



Please contact Express Scripts at **1-877-860-9256**.

Reconstructive Surgery

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

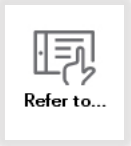


Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be provided if performed for the correction of functional disorders. For example, when a scar does not allow full function of a hand and a surgical procedure to remove the scar will achieve full function. Reconstructive Surgery requires Prior Authorization. For information regarding Reconstructive Surgery following a Mastectomy and Prophylactic Mastectomy, refer to the Women's Healthcare Section.

Rehabilitation and Therapy

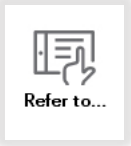
This benefit has one or more exclusions as specified in the Exclusions section.

Cardiac Rehabilitation Services



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

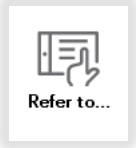
Pulmonary Rehabilitation Services



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

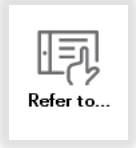
Short-term Rehabilitation Services

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



- Outpatient physical and occupational therapy require that your Provider must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in your condition. Refer to your *Summary of Benefits and Coverage* for your visit limitations.
- The treatment plans that define expected Significant Improvement must be established at the initial visit. Therapy treatments must be provided and/or directed by a licensed physical therapist or occupational therapist.
- Treatments by a physical therapist or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist.
- Massage therapy is only Covered when provided by a licensed physical therapist and as part of a prescribed Short-term rehabilitation physical therapy program. Refer to your *Summary of Benefits and Coverage* for your Cost-Sharing amount.
- Outpatient speech therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Speech therapy is Covered when provided by a licensed or certified speech therapist.

Coverage is subject to the following **limitations**:

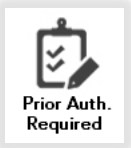


- Your Provider must determine, in advance, in consultation with us, that speech therapy can be expected to result in Significant Improvement in your condition. Refer to your *Summary of Benefits and Coverage* for your visit limitations and Cost Sharing.

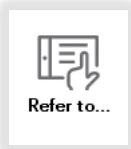
If your Short-Term Rehabilitation therapy is provided in an Inpatient setting (such as, but not limited to, Rehabilitation Facilities, Skilled Nursing Facilities, intensive day-Hospital programs that are delivered by a Rehabilitation Facility) or through Home Health Care Services, the therapy is not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

Skilled Nursing Facility Care

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



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



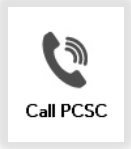
Refer to your *Summary of Benefits and Coverage* for your visit limitations.

Smoking Cessation Counseling/Program

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

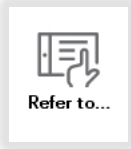
Coverage is provided for Diagnostic Services, Smoking Cessation Counseling and pharmacotherapy. Medical services are provided by licensed Healthcare Professionals with specific training in managing your Smoking Cessation Program. The program is described as follows:

- Individual counseling at a Provider's office is Covered under the medical benefit. The non-specialist Copayment applies.
- Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Provider. No Cost Sharing will apply and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. You may want to utilize these services.



For more information contact our Presbyterian Customer Service Center at **(505) 923-7787** or **1-855-261-7737**, Monday through Friday from 7 a.m. to 6 p.m. **TTY** users may call **711**.

Pharmacotherapy benefit Limitations



Please contact Express Scripts at **1-877-860-9256** for your Cost-Sharing amount.

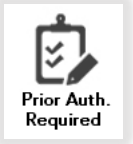
Telemedicine Services

PHP provides coverage for telemedicine services to the same extent that this agreement covers the same services when provided in-person. PHP will not impose originating-site restrictions. Coverage may be extended to out-of-network providers in instances where no in-network provider is accessible, as defined by network adequacy standards. A determination by PHP that services delivered through the use of telemedicine are not covered is subject to review and appeal.

Transgender Services

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

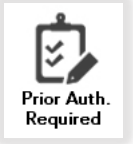
Transgender services related to Gender Dysphoria are covered when medically necessary. These services include gender affirming surgeries, hormone therapy, laboratory services, mental healthcare, and all related medical visits.



Transgender services with a diagnosis of Gender Dysphoria, please contact the Presbyterian Health Plan for detailed information. Prior Authorization is required.

Transplants

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



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

Human Solid Organ transplant benefits are Covered for:

- Kidney.
- Liver.
- Pancreas.
- Intestine.
- Heart.
- Lung.
- Multi-visceral (three or more abdominal Organs).
- simultaneous multi-organ transplants – unless investigational.
- pancreas islet cell infusion.

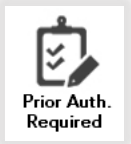
- Meniscal Allograft.
- Autologous Chondrocyte Implantation – knee only.
- Bone Marrow Transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high-dose chemotherapy. Bone marrow transplants are Covered for the following indications:
    - Multiple myeloma.
    - Leukemia.
    - Aplastic anemia.
    - Lymphoma.
    - Severe combined immunodeficiency disease (SCID).
    - Wiskott Aldrich syndrome.
    - Ewing's Sarcoma.
    - Germ cell tumor.
    - Neuroblastoma.
    - Wilms Tumor.
    - Myelodysplastic Syndrome.
    - Myelofibrosis.
    - Sickle cell disease.
    - Thalassemia major.

If there is a living donor that requires surgery to make an Organ available for a Covered transplant for our Member, Coverage is available for expenses incurred by the living donor for surgery, laboratory and X-ray services, Organ storage expenses, and Inpatient follow-up care only. We will pay the Total Allowable Charges for a living donor who is not entitled to benefits under any other health benefit plan or policy.

Limited travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be Covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be Covered for both out of state and in state, up to a maximum of $150 per day for the transplant recipient, live donor and one other person combined. Benefits will only be Covered for transportation, lodging and meals and are **limited** to a lifetime maximum of $10,000. All Organ transplants must be performed at site that we approve and require Prior Authorization.

Women's Healthcare

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



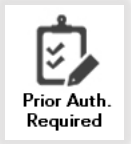
The following Woman's Healthcare Services, in addition to services listed in the Preventive Care Section are available for our female Members under the Women's Health and Cancer Rights Act (WHCRA). Inpatient Hospital services require Prior Authorization.

Obstetrical/Gynecological care includes:

- Annual exams.
- Care related to pregnancy.
- Miscarriage.
- Therapeutic abortions.
- Elective abortions up to 24 weeks.
- Other obstetrical/gynecological services.

Prenatal Maternity care benefits include:

- Prenatal care.
- Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus).
- Visits to an Obstetrician.
- Certified Nurse-midwife.
- Midwife.
- Medically Necessary nutritional supplements as determined and prescribed by the attending Provider. Prescription nutritional supplements require Prior Authorization.
- Childbirth in a Hospital or in a licensed birthing center.

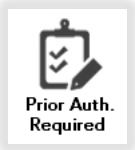


Maternity Care

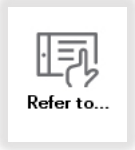
In Accordance with the Newborns' and Mothers' Health Protection Act (the Newborns' Act), the following benefits are Covered:

- Maternity Coverage is available to a mother and her newborn, if a Member, for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. Maternity In-patient Hospital admissions and birthing center admissions require notification to appropriately manage care. Your Provider will provide notification to the Health Plan of your maternity admission. Please see coverage for emergent/Prior Authorization admissions.
- In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her attending Provider. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists including, but not limited to, the criterion that family Members or other support person(s) will be available to the mother for the first few days following early discharge.

- Maternity Inpatient care in excess of 48 hours following a vaginal delivery and 96 hours following a cesarean section will be Covered if determined to be Medically Necessary by the mother's attending Provider. An additional stay will be considered a separate Hospital stay and requires Prior Authorization. Refer to your *Summary of Benefits and Coverage* for Cost-Sharing information.



- High-risk Ambulance services are Covered in accordance with the **Ambulance Services Benefits** section.



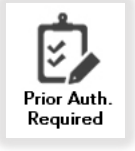
- The services of a Midwife or Certified Nurse Midwife are Covered, for the following:
    - The midwife's services must be provided strictly according to their legal scope of practice and in accordance with all applicable State licensing regulations which may include a supervisory component.
    - The services must be provided in preparation for or in connection with the delivery of a newborn.
    - For purpose of Coverage under this Agreement, the only allowable sites of delivery are a Hospital or a licensed birthing center. Elective Home Births and any prenatal or postpartum services connected with Elective Home Births are not Covered. Elective Home Birth means a birth that was planned or intended by the Member or Provider to occur in the home.
    - The combined fees of the midwife and any attending or supervising Providers, for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Provider had he/she been the sole Provider of those services.

Newborn Care

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

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

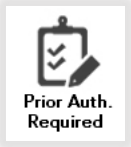
- If the above conditions are not met, we will not enroll the newborn for Coverage until the next Annual Group Enrollment Period.
- Neonatal care is available for the newborn of a Member for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a Cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, it is considered a separate Hospital stay and requires Prior Authorization. Refer to your *Summary of Benefits and Coverage* for your Cost-Sharing amount.



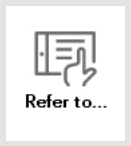
- Benefits for a newborn who is a Member shall include Coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Where necessary to protect the life of the infant Coverage includes transportation, including air Ambulance Services to the nearest available Tertiary facility. Newborn Member benefits also include Coverage for newborn visits in the Hospital by the baby's Provider, circumcision, incubator, and routine Hospital nursery charges.
- A newborn of a Member's Dependent child **cannot** be enrolled unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by the court as the newborn's legal guardian.

Additional Women's Healthcare Benefits

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



    - Coverage for Medically Necessary surgical removal of the breast (mastectomy) is for not less than 48 hours of Inpatient care following a mastectomy and not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless you and the attending Provider determine that a shorter period of Hospital stay is appropriate.
    - Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer is subject to Cost-Sharing amounts consistent with those imposed on other benefits. Refer to your *Summary of Benefits and Coverage* for Cost-Sharing amounts.



    - Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). Two bras per year are Covered for Members with external breast prosthesis.
    - As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast, if necessary, to produce symmetrical appearance.
    - Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy.
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- The Alpha-fetoprotein IV screening test for pregnant women, generally between 16 and 20 weeks for pregnancy, to screen for certain genetic abnormalities in the fetus.
- Coverage for the preventive screening of women who have family members with breast, ovarian, tubal or peritoneal cancers with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2).
- Women with positive screening results may receive genetic counseling and, if indicated after counseling, BRCA testing as determined by her healthcare Provider.

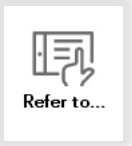
General Limitations

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

Benefit Limitations

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

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



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

Coverage while away from the Service Area

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

Major Disasters

In the event of any major disaster, epidemic or other circumstances beyond our control, we shall render or attempt to arrange Covered Benefits with In-network Providers insofar as practical, according to our best judgment, and within the limitations of facilities and personnel as are then available. However, no liability or obligation shall result from nor shall be incurred for the delay or failure to provide any such service due to the lack of available facilities or personnel if such lack is the result of such disaster, epidemic or other circumstances beyond our control, and if we have made a good-faith effort to provide or arrange for the provision of such services. Such circumstances include complete or partial disruption of facilities, war, act(s) of terrorism, riot, civil insurrection, disability of a significant part of a Hospital, our personnel or In-network Providers or similar causes. This provision does not impose any limitation on the availability of Coverage for services provided by Out-of-network Providers.

Prior Authorization

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

Exclusions

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

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

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

Emergency Healthcare Services – Use of an emergency facility for non-emergent services is not Covered. Non-emergency care when traveling outside the U.S.

Ambulance Services

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

Autopsies

Autopsy costs for deceased Members are not Covered.

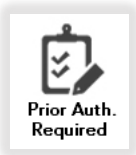
Before or After the Effective Date of Coverage

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

Clinical Trials

Any Clinical Trials provided outside of New Mexico, as well as those that do not meet the requirements indicated in the Benefits Section, are not Covered.

Costs of the Clinical Trial that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources are not Covered.



Services from Out-of-network Providers, unless services from an In-network Provider is not available are not Covered. Prior Authorization is required for any Out-of-network Services and such services must be provided for in New Mexico.

The cost of a non-FDA approved Investigational drug, device or procedure is not Covered.

The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Clinical Trial is not Covered.

Costs associated with managing the research that is associated with the Clinical Trials are not Covered.

Costs that would not be Covered if non-investigational treatments were provided are not Covered.

Costs of tests that are necessary for the research of the Clinical Trial are not Covered.

Costs paid for or not charged by the Clinical Trial Providers are not Covered.

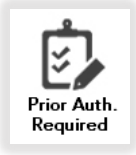
Care for Military Service Connected Disabilities

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

Certified Hospice Care Benefits

Certified Hospice Care Benefits are not Covered for the following services:

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



- Provider visits by other than a Certified Hospice Provider.
- Ambulance services.

Charges in Excess of Medicare Allowable Unreasonable

Charges that we determine to be in excess of Medicare Allowable and charges we determine to be unreasonable based on usual, customary, and reasonable charges are not Covered.

Clothing or Other Protective Devices

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

Clinical Preventive Health Services

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

Immunizations for the purpose of foreign travel are not Covered.

Complementary Therapies

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

- **Acupuncture** – Except as specified under Complementary Therapies in the Benefits section.
- **Chiropractic Services** – Except as specified under Complementary Therapies in the Benefits section.
- **Biofeedback** – Except as specified under Complementary Therapies in the Benefits section.

Cosmetic Surgery

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

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

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

Cosmetic Treatments, Devices, Orthotics, and Prescription Drugs/Medications

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

Costs for Extended Warranties and Premiums for Other Insurance Coverage

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

Dental Services

Dental care and dental X-rays are not Covered, except as provided in the Benefits section.

Dental implants are not Covered.

Malocclusion treatment, if part of routine dental care and orthodontics, is not Covered.

Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are not Covered, unless the disorder is trauma related.

Diabetes Services

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

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

Durable Medical Equipment

Upgraded or deluxe Durable Medical Equipment is not Covered.

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

Duplicate Durable Medical Equipment items (i.e., for home and office) are not Covered.

Repair and Replacement

Repair or replacement of Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience is not Covered.

Repair and replacement of items under the manufacturer or supplier's warranty are not Covered.

Additional wheelchairs are not Covered, if the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair.

Orthotic Appliances

Functional foot Orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints are not Covered, except for patients with diabetes or other significant peripheral neuropathies.

Custom-fitted Orthotics/Orthosis are not Covered except for knee-ankle-foot (KAFO) Orthosis and/or ankle-foot Orthosis (AFO) except for Members who meet national recognized guidelines.

Prosthetic Devices

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

Surgical Dressing

Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, adhesive bandages, gauze (such as four-by-fours), and elastic wrap bandages are not Covered, except when provided in a Hospital or Provider's office or by a Home Health professional.

Gloves are not Covered, unless part of a wound treatment kit.

Elastic Support hose are not Covered.

Eyeglasses and Contact Lenses

Routine vision care and Eye Refractions for determining prescriptions for corrective lenses are not Covered, except as identified in the Benefits section.

Corrective eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, are not Covered except as identified in the Benefits section.

Eye refractive procedures including radial keratotomy, laser procedures, and other techniques are not Covered.

Visual training is not Covered.

Eye movement therapy is not Covered.

Exercise Equipment, Personal Trainers, Club Memberships

Exercise equipment, videos, and personal trainers are not Covered except as provided for under the Unique Services Reimbursement Program for the Active Plan.

Experimental or Investigational drugs, Diagnostic Genetic Testing, Medicines, Treatments, Procedures, or Devices

Experimental or **Investigational** drugs, diagnostic genetic testing, medicines, treatments, procedures, or devices are not Covered.

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

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, phase II, or phase III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by State law, the drug or device is used for a purpose that is not approved by the FDA; or
- Testing is Covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient and if approved by the FDA. Routine genetic testing is not Covered; or
- For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in state law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure;

or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, "Experimental" or "Investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

Extracorporeal Shock Wave Therapy

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

Foot Care

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

Genetic Inborn Errors of Metabolism Coverage

Genetic Inborn Errors of Metabolism (IEM) Coverage does not include the following items:

- Food substitutes for lactose intolerance or other carbohydrate intolerances, including soy foods or elemental formulas or other Over-the-counter (OTC) digestive aids are not Covered, unless listed as a Covered Over-the-counter (OTC) medication on our *Formulary*.
- Ordinary food that might be part of an exclusionary diet are not Covered.
- Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM are not Covered.
- Special Medical Foods for conditions that are not present at birth are not Covered.
- Dietary supplements and items for conditions including, but not limited to, Diabetes Mellitus, Hypertension, Hyperlipidemia, Obesity, Autism Spectrum Disorder, Celiac Disease and Allergies to food products are not Covered.

Hair loss (or baldness)

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

Home Health Care Services/Home Intravenous Services and Supplies

Private duty nursing is not Covered.

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

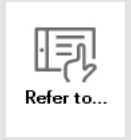
Hospital Services

Rehabilitation is not Covered as part of acute medical detoxification.

Mental Health and Alcohol and Substance Use Disorder

Mental Health

- Codependency treatment is not Covered.
- Bereavement, pastoral/spiritual and sexual counseling are not Covered.
- Psychological testing when not Medically Necessary is not Covered.
- Special education, school testing or evaluations, educational counseling, therapy or care for learning deficiencies or disciplinary problems are not Covered. This applies whether or not associated with manifest mental illness or other disturbances except as Covered under the Family, Infant and Toddler Program. Refer to the Benefits section.



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

Alcoholism Services and Substance Use Disorder Services

- Treatment in a halfway house is not Covered.
- Codependency treatment is not Covered.
- Bereavement, pastoral/spiritual and sexual counseling are not Covered.
- Court-ordered treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Use Disorder programs, is not Covered.

Nutritional Support and Supplements

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

Provider Services

Services provided by an Excluded Provider are not Covered. Any benefit or service, including pharmaceuticals, provided by an Excluded Provider as defined and maintained by the following regulatory agencies: Department of Health and Human Services; Office of the Inspector General (OIG); U.S. Department of Health; the General Services Administration; and the Office of Personnel Management, Office of Inspector General, which includes, but is not limited to the:

- Excluded Parties Lists System (EPLS).
- List of Excluded Individuals/Entities (LEIE).

- Office of Personnel Management (OPM).

Office Visits

- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided are not Covered.

Infertility services, listed below, are not Covered.

- Reversal of voluntary sterilization.
- Donor sperm.
- In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization.
- Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue.

Reconstructive Surgery for Cosmetic Purposes

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

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

Rehabilitation and Therapy

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

- Athletic trainers or treatments delivered by Athletic trainers.
- Vocational Rehabilitation Services.
- Long-term Therapy or Rehabilitation Services. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered Long-term Rehabilitation when:
    - You have reached maximum rehabilitation potential.
    - You have reached a point where Significant Improvement is unlikely to occur.
    - You have had therapy for four consecutive months.
    - Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, Cerebral Palsy, and Developmental Delays not associated with a defined event of illness or injury.
- Treatment of chronic conditions. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, and Cerebral Palsy.

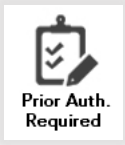
Speech therapy services listed below are not Covered:

- Therapy for stuttering.
- Hearing Aids and the evaluation for the fitting of Hearing Aids, except for school aged children under 18 years old (or under 21 years of age if still attending high school).
- Additional benefits beyond those listed in the Speech Therapy Benefit section.

Services for Which You or Your Dependent are Eligible under Any Governmental Program

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

Services Requiring Prior Authorization When Out-of-Network



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

Sexual Dysfunction Treatment

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

Skilled Nursing Facility Care

Custodial or Domiciliary care is not Covered.

Smoking Cessation Services

Smoking Cessation services listed below are not Covered:

- Hypnotherapy for Smoking Cessation Counseling.
- OTC drugs, unless listed as a Covered OTC medication on our *Formulary*.
- Acupuncture for Smoking Cessation Counseling.

Thermography Services

Thermography Services are not Covered.

Transplant Services

Transplant Services listed below are not Covered:

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

Treatment While Incarcerated

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

Women's Healthcare

Elective abortions after 24 weeks of pregnancy are not Covered.

Maternity and newborn care, as follows, are not Covered:

- Use of an emergency facility for non-emergent services.
- Elective Home Birth and any prenatal or postpartum services connected with an Elective Home Birth. Allowable sites for a delivery of a child are Hospitals and licensed birthing centers. Elective Home Birth means a birth that was planned or intended by the Member or Provider to occur in the home.

Work-related Illnesses or Injuries

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

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

Termination

How Coverage Stops

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

- The period for which premiums are paid.
- On the date when eligibility ceases.
- When this Plan ends.

If a Dependent becomes ineligible due to age, coverage ceases at the end of the month after the applicable birthday. If a Dependent loses eligibility due to marriage or divorce, coverage ends on the date of marriage or divorce.

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

How to Disenroll Dependents

When you lose a Dependent through marriage, death, divorce, annulment, or legal separation, or a Dependent is ineligible due to age, please submit an Application to disenroll the Dependent from your coverage. Contact your agency group representative for the necessary forms.

Certificate of Coverage

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

Leave Without Pay

The City of Albuquerque makes no contribution in these instances. Premium payment must be made on the payday of that current pay period. Failure to pay premiums on the due date while on leave without pay will result in cancellation of coverage. If coverage is dropped or terminated while you are on leave without pay, you are subject to the late applicant provisions, except employees who are called to active military/reserve duty. It is extremely important to pay close attention to this requirement so that coverage is not lost. Please make prompt arrangements with your agency group representative.

Leave-without-pay guidelines apply to authorized leaves of absence, disability leaves, or temporary layoffs. If an employee is laid off, coverage may continue for three months, subject to extensions. If an employee is given a leave of absence, coverage may continue for the full time of the leave of absence, not to exceed one year. If an employee is disabled, coverage may

continue for up to one year from the date of disability. See your agency group representative for further information.

Continuation of Coverage Under the Family and Medical Leave Act

If you take a leave of absence that qualifies as a Family and Medical Leave under the Family and Medical Leave Act of 1993 (an FMLA leave), medical coverage for you and your family Members continues as long as you continue paying your portion of the cost of coverage during the FMLA leave. Your agency group representative will advise you of the methods available to continue paying for your coverage. If you elect to discontinue medical coverage during an FMLA leave and subsequently return to work, your coverage will be reinstated with no waiting period or pre-existing condition limitation. For additional information on FMLA leave and the effect on your benefits, please contact your agency group representative.

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

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

Continuation of Coverage Under COBRA

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

If you are an employee of the City of Albuquerque covered by this healthcare Plan, you have the right to choose this continuation coverage if you lose your group health coverage due to a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct.

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

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

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

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

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

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

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

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

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

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

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

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

COBRA and the Family and Medical Leave Act

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

- The date you unequivocally inform your agency group representative that you are not returning at the end of the leave.
- The date your leave ends, assuming you do not return.
- The date the FMLA entitlement ends.

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

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

Claims

This is an HMO Plan wherein the In-network Providers have agreed to file your claims directly to PHP and payment is made directly to the Provider. PHP has arranged to provide additional coverage with National PPO Network Providers when you obtain covered services outside of New Mexico. If you obtain covered services outside of New Mexico from National PPO Network Providers, they will file the claim with PHP for you.

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. Out-of-network Providers may also file claims for you. However, you will be required to submit claim forms when your Out-of-network Provider does not file them for you. Please submit all claims as the services are received and attach the itemized bill for services or supplies. Do not file for the same service twice unless requested by a Presbyterian Customer Service Center representative.

Note: When the Out-of-network Provider does not bill for you, you will be required to pay that Provider.

The Member claim forms are available from your agency group representative, the PHP website at **www.phs.org** or a Presbyterian Customer Service Center representative. Please mail the claim forms and itemized bills to:

Presbyterian Health Plan
Attn: City of Albuquerque 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.

Claims Outside the United States

Even overseas, this Plan's coverage travels with you. If you need Hospital or Provider care, claims should be handled the same way as described in "Out-of-network Claims," above. Members are responsible for ensuring that claims are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States.

Itemized Bills

Itemized bills must be submitted on billing forms or the Provider's letterhead stationery and must show all of the following:

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

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

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

How Payments are Made

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

Provider payments are based upon In-network and MP/PHCS agreements and the Negotiated Fee Schedule as determined by PHP. You are responsible for paying the Deductible and/or any Copayments, Coinsurance, and charges for non-Covered Services.

If you obtain services from an Out-of-network Provider, you are responsible for paying all Copayments, Coinsurance, and charges for non-Covered Services.

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 PHP.

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

Overpayments

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

Effects of Other Coverage

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

Coordination of Benefits

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

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

- Employee/Dependent Rule
  - The plan, which covers you as an employee, pays first.
  - The plan, which covers you as a Dependent, pays second.
- Birthday Rule for Dependent children of parents who are **not** separated or divorced
  - The plan, which covers the parent whose birthday falls earlier in the year, pays first. The plan, which covers the parent whose birthday falls later in the year, pays second. The birthday order is determined by the month and the day of birth, not the year of birth.
  - If both parents have the same month and day of birth, the plan that Covered the parent longer, will pay claims first. The plan which covered the parent for a shorter period of time pays second.
- Dependent children of separated or divorced parents
  - The plan of the parent decreed by a court of law to have responsibility for medical coverage pays first.
  - In the absence of a court order:
    - The plan of the parent with physical custody of the child pays first.
    - The plan of the Spouse of the parent with physical custody (i.e., the stepparent) pays second.
    - The plan of the parent not having physical custody of the child pays third.
- Active/Inactive Employee
  - The plan, which covers you as an active employee (or Dependent of an active employee), pays first.
  - The plan, which covers you as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.
- Longer/Shorter Employment
  - In the case where you are the Subscriber under more than one group health insurance policy, then the plan that has Covered you for a longer period of time will pay first. A change of insurance carrier by the group employer does not constitute the start of a new plan.

- No Coordination Provision
    - In spite of the rules listed above, the plan that has no provision regarding coordination of benefits will pay first.
- If you are covered under a motor vehicle or homeowner's insurance policy which provides benefits for medical expenses resulting from a motor vehicle accident or accident in your own home, you shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are covered by the motor vehicle or home owner's insurance policy. If we have provided such benefits, we shall have the right to recover any benefits we have provided from you or from the motor vehicle or homeowner's insurance to the extent they are available under the motor vehicle or homeowner's insurance policy.
- If you or your Dependents are Covered by COBRA continuation and are also Covered by another group plan, you shall receive our Covered Benefits to the extent that we will be secondary payer of all eligible charges, subject to the terms, conditions, exclusions and limitations of this Agreement.

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

For purposes of coordination of benefits:

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

Medicare

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

Medicaid

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

- The Human Services Department has paid or is paying benefits on behalf of the Member under the state's Medicaid program pursuant to Title XIX and/or Title XXI of the Federal Social Security Act.

- The payment for the services in question has been made by the state Human Services Department to the Medicaid Provider.

Subrogation (Recovering Healthcare Expenses from Others)

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

By way of illustration only, our right of subrogation includes, but is not limited to, the right to be repaid when you recover money for personal injury sustained in a car accident. The subrogation right applies whether you recover directly from the wrongdoer or from the wrongdoer's insurer, or from your uninsured motorist insurance coverage. You agree to sign and deliver to us such documents and papers as may be necessary to protect our subrogation right. You also agree to keep us advised of:

- Any claims or lawsuits made against any person, firm or entity responsible for any injuries for which we have paid Covered Benefits.
- Any claim or lawsuit against any insurance company, or uninsured or underinsured motorist insurance carrier.

Settlement of a legal claim or controversy without prior notice to us is a violation of this Agreement. In the event you fail to cooperate with us or take any other action, through agents or otherwise, which interferes with the exercise of our subrogation right, we may have, and hereby expressly reserve, all legal remedies available to us.

When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both you and us, we will, upon request by you or your attorney, share such collection costs and legal expenses, in a manner that is fair and equitable, but only if we receive appropriate documentation of such collection costs and legal expenses.

Summary of Health Insurance Grievance Procedures

Appeal and Grievances

Appeals Procedures

PHP will administer Level I and Level II appeals on behalf of Employer according to the procedures set forth below. These procedures apply to appeals of adverse benefit determinations based on medical necessity, appropriateness, healthcare setting, level of care, effectiveness of a covered benefit and/or rescission of coverage in the event of fraud or intentional misrepresentation of material fact. (Note: PHP responds to all urgent or expedited requests within 24 hours of receiving the request.)

Level I Appeals

To initiate a Level I appeal, a Plan Participant (all references to Participant in the Appeals and Grievance section of the SPD include the Employee and/or covered Dependent(s)) must submit a request for an appeal to PHP within 180 days of receipt of a notice of denial of items or services under the Plan. The Participant must tell PHP the reason why the denial should be overturned and include any information supporting the appeal. PHP will acknowledge to the Participant in writing within one working day that it has received a request for an Appeal. The acknowledgement letter will contain the name, address, and direct telephone number of an individual at PHP who may be contacted regarding the appeal.

Time Frames for Processing Appeals of Adverse Determinations

Level I appeals involving the review of a denial of coverage for services before they are received (pre-service) will be completed within 15 working days of receipt of a standard appeal requests. Appeals involving the review of a denial of coverage of services after they are received (post-service) will be completed within 40 working days. PHP may extend the review period for a maximum of 10 working days for pre-service requests and 20 working days for post-service requests if PHP can: 1) show reasonable cause beyond PHP's control for the delay; 2) can show that the delay will not result in increased medical risk to the Participant; and 3) provide a written progress report to the Participant and the related provider within the 25- or 60-day review period. Participants must agree, in writing, to a request to extend a deadline.

Some appeals of pre-service denials relating to claims involving Urgent Care are processed on an expedited basis. Expedited decisions are made when a Participant's life or health, or ability to regain maximum function, would be jeopardized by following the standard appeal process and time frames; or, in the opinion of a provider with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In cases that require an expedited decision of a pre-service request, based at the request of a participating provider or Participant, a decision will be made within 72 hours of the receipt of the request. PHP **will not** conduct

expedited appeals for services already provided ("post service") to a Participant. If a Participant requests an expedited decision, a PHP Medical Director will review the request. If the medical director determines that the request for an expedited appeal is medically necessary, a decision will be made within 72 hours of the request. All required information will be transmitted between PHP, the applicable Provider, and the Participant by the quickest means possible. If the Medical Director determines that a request for an expedited appeal is not medically necessary, PHP will notify the applicable Participant and then process the appeal within 15 working days.

Internal Review of Appeal of Adverse Determination by Medical Director Level I

The appeal will be reviewed by a PHP Medical Director not involved in the initial determination, nor by a subordinate of the person resolving the claim initially. The Medical Director will re-review the request to make a determination regarding whether the requested healthcare services are medically necessary and covered under the Plan. If medical judgment is involved, the PHP medical director will utilize input from a healthcare professional with training and experience in the relevant field.

Notice of Decision on Appeal of Adverse Determination by Medical Director

If the Medical Director decides to reverse an initial adverse determination, PHP will approve coverage of the services. The applicable Participant and the applicable provider will be notified by mail or electronic means (fax, e-mail, etc.) within two working days of such decision.

If the Medical Director decides to uphold an initial adverse determination, the applicable Participant and the applicable provider will be notified by telephone within 24 hours that the adverse determination has been upheld and by written or electronic means within one working day of the telephone notification. Written notification must be provided in a linguistically appropriate manner. The notice will provide the opportunity to request diagnosis and treatment codes and their meanings. The Participant will be given the choice of whether or not to pursue a Level II appeal. If the Participant does not wish to pursue the appeal, PHP will mail to the participant written notification of the decision and confirmation of the Participant's decision not to pursue the appeal within three working days of the Medical Director's decision.

If PHP is unable to contact the Participant by telephone within 72 hours after making the decision to uphold the initial adverse determination, then PHP will notify the Participant by mail of the decision. Included in the notification will be a self-addressed stamped response letter which asks whether the Participant wants to pursue the Level II appeal by asking the Participant to check "yes" or "no" on the letter. If the Participant does not return the letter within 10 working days, PHP will again try to contact the Participant by telephone. If the Participant does not respond to PHP's telephone calls and does not return the response letter within 20 working days of the written notification to uphold the initial decision, PHP will close the file, documenting that the Participant has not responded.

If the appeal was processed on an expedited basis, then a Level II appeal will automatically proceed. This review will be completed within 72 hours. If an expedited review is conducted

during a Participant's stay or course of treatment, coverage for healthcare services will be continued subject to applicable Co-payments and Deductibles until PHP makes a decision and notifies the Participant. If the Participant does not make an immediate decision to pursue a Level II appeal, or if the Participant requests additional time to supply supporting documents or information, the time frames described above for completing an appeal will be extended to include the additional time the Participant needs.

Internal Panel Review of Adverse Determination - Level II

If the Participant requests a Level II appeal, then PHP will conduct the appeal on behalf of Employer according the process set forth below.

Internal Panel Review Committee

An internal panel review committee will consider the appeal. The Internal Panel Review Committee will consist of PHP staff and one or more healthcare or other professionals. At least one of the healthcare professionals will have training and experience in the relevant field and practice in a specialty that would typically manage the case that is the subject under appeal or be mutually agreed upon by the Participant and PHP. Panel members must be present physically or by video or telephone conferencing to hear the appeal. A panel member who is not present to hear the appeal either physically or by video or telephone conferencing will not participate in the decision.

Notice of Internal Panel Review Hearing

PHP will notify the Participant in writing of the date, time, and place of the internal panel review hearing. The notice will also advise the Participant of the Participant's appeal rights. Such rights include: attending and participating in the internal panel review; presenting a case to the internal panel review committee; submitting supporting material both before and at the internal panel review; asking questions of any representative of PHP; asking questions of the healthcare professionals on the internal panel review committee; and being assisted or represented by a person of the Participant's choice, including legal representation. A Participant may hire a specialist to participate in the internal panel review at the Participant's own expense. This specialist may not participate in making the decision.

If the Participant chooses to have legal representation at the hearing, the Participant must notify PHP prior to the hearing. Failure to notify may require rescheduling of the hearing within the time frame allowed to complete the appeal. If PHP or Employer has an attorney present to protect its interests, a notice will advise the Participant of that and advising that the Participant may wish to obtain legal representation of his or her own. PHP will notify the Participant of this at least three working days before the hearing.

PHP will accept a Participant's reasonable request for postponement of a hearing. Time frames previously described for completing an appeal will be extended during the period of any postponement.

Time Frames for Internal Panel Review Committee

No fewer than three working days prior to the internal panel review, PHP will provide the participant with: pertinent records; treating Provider's recommendation; the SPD; a copy of the notice of the adverse determination; uniform standards relevant to the Participant's medical condition used by the internal panel in reviewing the adverse determinations; information provided to or received by any medical consultants retained by PHP; and all other evidence or documentation relevant to reviewing the adverse determination. The Participant may review the claim file and present evidence and testimony as part of the appeals process, to the extent required by Applicable Law. Applicable Laws is defined as the regulations issued in the July 23, 2010 Federal Register, June 24, 2011 Federal Register and subsequent guidance, including any superseding regulations. In addition to the claim file, the Participant may review any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim.

The Internal Panel Review Committee will complete its review for expedited cases within 72 hours of receipt of the request if the Participant's life or health would be jeopardized or the participant's ability to retain maximum function would be jeopardized by a delay; or, in the opinion of provider with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Internal Panel Review Committee will complete its review of a standard appeal within time frames previously noted. PHP will notify the participant and the treating Provider of the Internal Panel Review Committee's decision by telephone within 24 hours of making a decision, and in writing or by electronic means within one working day of the telephone notice.

Individuals in Urgent Care situations and individuals receiving an ongoing course of treatment may proceed with an expedited external review by an Independent Review Organization (IRO) at the same time as the internal review process occurs.

Notice of Decision of Internal Panel Review Committee

The written notice will contain the following: the names, titles, and qualifying credentials of the persons on the Internal Panel Review Committee; a statement of the Internal Panel Review Committee's understanding of the nature of the appeal and all pertinent facts; an explanation of the clinical or other rationale for the decision; and for coverage determinations, identification of the Plan provision relied upon in reaching the decision; and the opportunity to request diagnosis and treatment codes and their meanings. The notice will also explain why each provision did or did not support the decision regarding coverage of the requested service. For medical necessity determinations, it will include the uniform standards relevant to the Participant's medical condition, an explanation whether each supported or did not support the decision regarding the medical necessity of the coverage decision, and reference to evidence or documentation considered by the Internal Panel Review Committee in making the decision. The notice will also explain the Participant's right to request an external review by an IRO. Review by an IRO is

voluntary and explained in the next section. The Participant must receive the written notice in a linguistically appropriate manner.

Level III – External Review

If the Participant dissatisfied with the decision of the Internal Panel Review Committee, the Participant may request an external review by an IRO as defined by Applicable Law. An IRO is an independent review organization, external to the Employer and PHP that utilizes independent providers with appropriate expertise to perform external reviews of appeals. The IRO will, with respect to claims involving investigational or experimental treatments ensure adequate clinical and scientific experience and protocols are taken into account as part of the external review process. In rendering a decision, the IRO will consider any appropriate additional information submitted by the Participant and will follow the plan documents governing the Participant's benefits.

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

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

There are no fees or costs imposed on a Participant for the external review of an appeal. The Participant's decision as to whether or not to submit a denial of an appeal for external review will have no effect on the Participant's rights to any other benefits under the Plan.

When an appeal is denied by PHP, the Participant will receive a letter that describes the process to follow if the Participant wishes to pursue an external review of an appeal through an IRO.

If a Participant files a request for an external review of an appeal with an IRO:

The external review may only be requested after exhaustion of the required Internal Appeal procedures under the Plan, unless an expedited external review of a claim involving Urgent Care or an ongoing course of treatment is requested. Accordingly, the Participant must first submit an appeal with PHP and receive a denial of appeal before requesting an external review of an appeal with an IRO.

After a Participant receives a denial of an appeal, the Participant must submit the request for external review of appeal with PHP in writing within 60 days from the date of receipt of the adverse benefit determination, extended to the next working day if the date falls on a weekend or federal holiday.

PHP will forward a copy of the final appeal denial letter and all other pertinent information that was reviewed in the appeal to the IRO. The Participant may also submit additional information to be considered. The Participant will have at least five business days to submit additional information to the IRO.

Within five days after receipt of the request for external review, the Plan will complete a preliminary review to determine if the Participant was covered under the plan at the time the service was requested or provided; whether the adverse benefit determination relates to the Participant's failure to meet the eligibility requirements of the Plan; whether the Participant has exhausted the Plan's internal appeal process; and whether the Participant has provided all of the information and forms required to process an external review. Within one business day after completion of this preliminary review, the Plan will provide the Participant written notification giving any reasons for the ineligibility of the request for external review and describing the information or materials required, and the Plan will allow the Participant to perfect a request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

The Participant will be notified of the decision of the IRO within 45 days of the receipt of the request for the external review of an appeal. The IRO's decision will include:

- A general description of the reason for the request for external review;
- The dates the IRO received the assignment to conduct the external review and the date of their decision;
- Reference to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching their decision, taking into account adequate clinical and scientific experience and protocols with respect to claims involving experimental or investigative treatments;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision;
- A statement that judicial review may be available; and
- Current contact information, including the phone number for any ombudsman established under the PHS Act.
- In the event of an expedited external appeal for claims involving Urgent Care, the IRO will make the decision as expeditiously as the Participant medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review and, if the notice is not in writing within 48 hours after the date of providing the verbal notice, the IRO will provide written confirmation of the decision to the Participant and the Plan. Written notice must be provided in a linguistically appropriate manner. The notice will provide the opportunity to request diagnosis and treatment codes and their meanings.

- The decision of the IRO will be binding on the Participant as well as the Plan, except to the extent there may be other remedies available under state law.

The statute of limitations or other defense based on timeliness is suspended during the time that an external review of your appeal is pending.

Administrative Grievance Procedures

Participants may file a grievance if they are dissatisfied with any aspect other than a request for healthcare services, including, but not limited to: administrative practices that affect the availability, delivery or quality of healthcare services; claims payment; handling or reimbursement for healthcare services; and terminations of coverage. If the participant is unable to resolve the grievance with a customer service representative, the participant may file a formal grievance by notifying a customer service representative.

Initial Internal Review - Level I

Once the request has been received, PHP will send the participant written acknowledgement of the grievance within three working days after receipt. The letter will contain the name, address, and direct telephone number of a PHP representative who may be contacted regarding the administrative grievance. The review of the grievance will be conducted by a PHP representative authorized to take action related to the grievance, if applicable, and will allow the participant to provide to PHP any information relevant to the grievance.

PHP will mail a written response to the participant within 15 working days of receipt of the grievance. PHP may extend the 15-day time frame when there is a delay in obtaining documents or records necessary for the review of a grievance, provided that PHP notifies the participant in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the participant and PHP.

PHP's response letter to the participant shall contain: the name, title, and qualifications of the person conducting the initial review; a statement of the reviewer's understanding of the nature of the grievance and pertinent facts; a clear and complete explanation of the reason for the response/decision; the Plan provisions relied on in reaching the response; a statement that the initial decision will be binding unless the participant submits a request for reconsideration within 20 working days of the receipt of the initial response; and a description of the procedures and deadlines for requesting reconsideration, including any necessary forms.

Reconsideration of Internal Review – Level II

If the participant is not satisfied with the outcome of the initial review, PHP will appoint a reconsideration committee consisting of PHP representatives who have not participated in the initial internal review, to review the grievance. The participant must request this committee hearing within 20 days after receiving the response letter, or the initial review decision will be final.

Reconsideration Committee

Upon receipt of a request for a reconsideration committee hearing, PHP will schedule and hold a hearing within 15 working days. The hearing will be held during regular business hours at a location reasonably accessible to the participant. The participant will have the opportunity to participate at the committee meeting in person, by conference call, video conferencing, or other technology, at PHP's expense. PHP will not unreasonably deny a request for postponement of the hearing.

Reconsideration Committee Hearing

PHP will notify the participant in writing of the hearing date, time, and place of the reconsideration committee hearing at least 10 working days in advance. The notice will advise the participant of his or her rights: to attend the hearing; to present a case to the committee; to submit supporting material both before and at the hearing; to ask questions of any representative of PHP; and be assisted or represented by a person of the participant's choice that may or may not be a legal representation. If PHP will have an attorney to represent its interests; the notice will advise the participant of this and that the participant may wish to obtain legal representation of his or her own. If the participant chooses to have legal representation at the hearing, the participant must notify the grievance department representative prior to the hearing. Failure to notify may require rescheduling of the hearing within the time frame allowed for administrative grievances. No fewer than three working days prior to the hearing, PHP will provide the participant with all the documents and information that the reconsideration committee will rely on in reviewing the grievance.

Decision of Reconsideration Committee

PHP will mail a written decision to the participant within seven working days after the committee hearing. The written decision will include the following: the names, titles, and qualifications of the persons on the committee; the committee's statement of the issues involved in the grievance; a clear and complete explanation of the rationale for the decision; the Plan provision(s) relied on in reaching the decision; references to the evidence or documentation relied on in reaching the decision; and a statement that the initial decision will be binding unless the participant submits a request for external review by Employer.

Records

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

Creation of Non-Medical Records

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

Accuracy of Information

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

Consent for Use and Disclosure of Medical Records

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

Professional Review

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

Confidentiality of Protected Health Information/Medical Records

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

What is PHI?

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

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

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

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

Access to PHI

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

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

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

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

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

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

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

Routine Uses and Disclosures of PHI

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

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

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

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

Consents/Authorizations

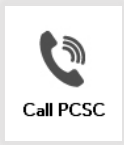
Although consent from you (or your legal guardian/Personal Representative) is not required to use or disclose PHI for certain purposes specified in the law, a Provider shall request that you (or your legal guardian/Personal Representative) sign a consent form permitting disclosure of medical records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

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

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

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

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



To request an Authorization Form, please contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711** or visit our website at **www.phs.org**. Authorization Forms will be kept in your medical record or enrollment file.

Members Who Are Unable to Give Consent/Authorization

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

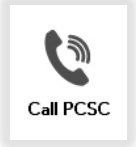
healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

Right to Request Amendments (Changes) to PHI

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

Process for Members to Request an Accounting of Disclosures of PHI

You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center by calling Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711** or visit our website at **www.phs.org**. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you to others without authorization from you.



Restriction of PHI Use or Disclosures

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

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

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

Use of Measurement Data

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

Internal Protection of Oral, Written and Electronic PHI Across PIC

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

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

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

Website Internet Information

We enforce security measures to protect PHI that is maintained on the website, network, software, and applications. We collect website traffic statistics that includes where visitor traffic comes from, how traffic flows within the website and the browser type.

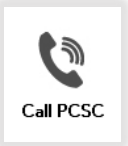
We also monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful. This includes personal information that you provide to us, such as your name, address, billing information, Health Benefit Plan enrollment status, etc., if you fill out a form on our website. We use your personal information to reply to your concerns. We save this information as needed to keep responsible records and handle inquiries.

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

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

Our policies and procedures prohibit sharing your PHI with any fully insured employer Group's plan sponsor without your (or your legal guardian/Personal Representative's) authorization. We are careful not to release PHI to your employer as part of routine financial and operating reports.

We may disclose summary health information that does not identify you to plan sponsors for allowable purposes. We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards as permitted by law.



If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7787** or **1-855-261-7737**. **TTY** users may call **711** or visit our website at **www.phs.org**.

Eligibility, Enrollment and Effective Dates

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

You must complete and return an enrollment form within 31 days of your eligibility date. If you don't elect coverage within 31 days of your eligibility date and later want coverage, you must wait until the next open enrollment period to receive coverage unless you have a qualified change in status or you are eligible as a result of a special enrollment event. If you have a qualified change in status or special enrollment event, you will be able to elect coverage within 31 days of the change.

Once you complete an enrollment form, your elections remain in effect through the Plan Year – from July 1 through June 30. Each year you will have an opportunity to change your group health plan elections. The change is effective the following July 1, you and your Dependents will be automatically re-enrolled in the Plan each year unless you complete a new enrollment form changing your election during the enrollment period.

How to Enroll Dependents

You may apply for coverage of your eligible dependents, which may mean changing from Employee only coverage to Coverage that Includes Dependent or Family Coverage. Each additional dependent added to your coverage must be enrolled within 31 days of becoming eligible for the Plan.

Newly adopted children are effective on the date of placement and must be enrolled within 31 days of that date.

When Coverage Starts

If you enroll on or before the day you become eligible, your coverage becomes effective the day you are eligible. If you enroll within 31 days of becoming eligible, your coverage becomes effective on the day that you enroll or the first day of the following pay period.

- Coverage begins on the first day of the current pay period if forms are completed and required documents are brought to New Employee Orientation or submitted to the Benefits Office by the end of the first week. If forms are submitted after that but within the 31-day enrollment period, coverage begins on the first day of the pay period following the submission of completed forms and verification of the dependent eligibility.

Contact your agency group representative for further details.

The Plan pays for Covered Services that a Member receives on or after the effective date of coverage.

Health Insurance Portability and Accountability 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 your agency group representative.

Changing of Coverage

Once you elect coverage, you generally cannot change your elections until the following switch enrollment period. However, there are certain circumstances when you may be eligible to change coverage earlier. You must request the change in coverage within 31 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.
- 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 notify your agency group representative, who will then notify the Claim Administrator, of any change in your coverage status, including a name or address change.

Family Status or Employment Status Changes (Qualifying Events)

You may make certain changes to your benefit elections within 31 days of a change in family/employment status. Evidence of a change in family/employment status must be provided to your agency group representative in order to change your benefit elections. Any change in coverage must correspond with the gain or loss of coverage and will become effective on the first pay period following the date the new benefit elections are made. The only exceptions would be birth and adoption, where the additional coverage would take place immediately upon

enrollment. The following family/employment status changes are recognized by the City of Albuquerque:

- Marriage or divorce;
- Legal Separation;
- 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);
- A change in legal responsibility for a child;
- The end of the month in which the Dependent child turns 26 years old;
- Qualification or disqualification of a domestic partner; and
- Change in employment status (regular part-time to regular full-time or vice versa).

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 31 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 31 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 31 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 EPO coverage. Carry it with you.

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

Your Member identification number and your group number are on your ID Card. Each of your Dependents will also receive an ID card. 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.

Glossary of Terms

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

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

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

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

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

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

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

Alcoholism means alcohol dependence or alcohol use disorder meeting the criteria as stated in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-5) for these disorders.

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

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

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

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

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

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

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

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

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

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

Calendar Year means the period beginning Jan. 1 and ending Dec. 31 of the same year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Culturally and Linguistically appropriate manner of notice means the notice that meets the following requirements:

- The Healthcare Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language.
- The Healthcare Insurer must provide, upon request, a notice in any applicable non-English language.
- The Healthcare Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Healthcare Insurer.

For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined by the Department of Health and Human services (HHS). The counties that meet this 10 percent standard, as determined by HHS, are found at **http://cciio.cms.gov/resources/factsheets/clas-data.html** and any necessary changes to this list are posted by HHS annually.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Disfigurement to the person.

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

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

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

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

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

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

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated does, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by State law, the drug or device is used for a purpose that is not approved by the FDA; or
- For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in State law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, "Experimental" or "Investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

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

Family, Infant and Toddler (FIT) Program means an early intervention services program provided by the Healthy Family and Children's Healthcare Services to eligible children and their families.

FDA means the United States Food and Drug Administration.

Formulary means a list of drugs approved for Coverage and the tier level at which each is Covered under this Agreement. Our Pharmacy and Therapeutics Committee continually updates this listing. A copy of this listing is available on our website at **www.phs.org** or by calling our Presbyterian's Customer Service Center at **(505) 923-7787** or **1-855-261-7737**, Monday through Friday, 7 a.m. to 6 p.m. **TTY** users may call **711**.

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

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

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

Grievant means any of the following:

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

Group means the legal entity which has contracted with us to obtain the benefits described in this Agreement for Subscribers and eligible Dependents, called Members, in return for periodic Prepayments specified in the Group Letter of Agreement (GLA). Then term "Group" as used herein to determine eligible Subscribers and Dependents, shall also include City Participating Governmental Entities and other entities approved by the Group and PHP. Employees of Participating Governmental Entities shall be entitled to all Healthcare Services and benefits accorded to the City of Albuquerque employees under this Summary Plan Description (SPD)

Agreement subject to its provisions. The City of Albuquerque shall act for the Group as the contracting entity and administrator of the plan.

Group Letter of Agreement (GLA) means the administrative agreement between PHP and the Group.

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

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

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

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

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

Healthcare Services means services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the Health Benefits Plan, physical and mental health services, including community based mental health services, and services for developmental disability or developmental delay.

Health Maintenance Organization (HMO) means any person who undertakes to provide or arrange for the delivery of basic Healthcare Services to Covered Persons on a prepaid basis, except for Cover Person responsibility for Cost Sharing (Deductibles, Coinsurance and/or Copayments).

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

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

Home Health Agency means a facility or program, which is licensed, certified or otherwise authorized pursuant to state laws as a Home Health Agency.

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

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

Hospital means an acute care general Hospital, which:

- Provides Inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed Providers.
- Is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.
- Is duly licensed to operate as an acute care general Hospital under applicable state or local law.

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

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

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

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

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

In-network Pharmacy means any duly licensed pharmacy, which has entered into an agreement with us to dispense Prescription drugs/Medications to our Members.

In-network Provider means any licensed Practitioner of the healing arts acting within the scope of his or her license who has entered into an agreement directly with us to provide Healthcare Services to our Members. It also means a Provider who, under a contract or through other arrangements with us, has agreed to provide Healthcare Services to Covered Persons, known as Members, with an expectation of receiving payment, other than Cost-Sharing Deductibles, Coinsurance and/or Copayments), directly or indirectly from us.

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

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

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

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

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

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

Maternity means Coverage for prenatal, intrapartum, perinatal or postpartum care.

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

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

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

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

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

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

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

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

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

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

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

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

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

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

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

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

Out-of-pocket Maximum means the most that a Member will pay, in total Cost Sharing, during the Contract Year. Once a Member has reached the Annual Out-of-pocket Maximum limit, we will pay 100 percent of the Medicare Allowable. The Annual Out-of-pocket Maximum includes Deductible, Coinsurance and Copayments. (including **Self-Administered Specialty Drugs**) Cost Sharing and does not include non-covered charges including charges incurred after the benefit maximum has been reached. Covered charges for In-network Provider services do not apply to the Out-of-network Provider Annual Out-of-pocket Maximum, and Covered charges for

Out-of-network Provider services do not apply to the In-network Provider Annual Out-of-pocket Maximum.

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

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

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

PPACA means Patient Protection and Affordable Care Act.

PPO means Preferred Provider Organization.

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

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

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

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

Prescription Drugs/Medications means those drugs that, by federal law, require a Provider's prescription for purchase (the original packaging of which, under the federal Food, Drug and Cosmetic Act, is required to bear the legend, Caution: Federal law prohibits dispensing without a prescription or is so designated by the New Mexico State Board of Pharmacy as one which may only be dispensed pursuant to a prescription).

Primary Care Provider (PCP) means a Healthcare Professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to Members, who may initiate their referral for specialist care, and who maintains continuity of patient care. Primary Care Providers shall include but not be limited to general Practitioners, family practice Providers, internists, pediatricians, and Obstetricians-Gynecologists, Provider Assistants and Nurse Practitioners. Other Healthcare Professionals may also provide primary care as

necessitated by a Member's healthcare needs. Members enrolled in the PPO plan have the choice of an In-network or Out-of-network Provider based on availability, without a referral.

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

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

Prospective Enrollee means an individual eligible for enrollment in a MHCP through that individual's group.

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

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

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

Reasonable/Prudent Layperson means a person who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Healthcare Services. A Reasonable/Prudent Layperson is considered to have acted "reasonably" if, after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention (including healthcare procedures, treatments, or services) could reasonably be expected to result in:

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

Reconstructive Surgery means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.

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

Registered Lay Midwife means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Rehabilitation Facility means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

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

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

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

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

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available 24 hours a day.

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

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

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

Significant Improvement means that:

- The patient is likely to meet all therapy goals for a reasonable number of visits of therapy or,
- The patient has met all therapy goals in the preceding visits of therapy, as specifically documented in the therapy record.

Skilled Nursing Facility means an institution that is licensed under state law to provide skilled care nursing care services.

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

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

Special Medical Foods means nutritional substances in any form that are used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require Prior Authorization through Presbyterian's Pharmacy Department.

Specialty Pharmacy – Presbyterian's In-network Pharmacy vendor that, under contract or other arrangement with us, provides Covered **Self- Administered Specialty Drugs** to Members.

Spouse - Legally married husband or wife.

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

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

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

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

Summary Plan Description (SPD) means this book.

Superintendent means The Superintendent of Insurance.

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

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

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

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

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

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

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

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

Urgent Care means Medically Necessary Healthcare Services provided in urgent situations for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention.

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

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

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

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

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

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

Exhibits

Notice of Nondiscrimination and Accessibility
Multi-Language Interpreter Services
Clickotine – Personalized Help to Quit Smoking
Presbyterian Baby Benefits
Presbyterian Employee Assistance Program
Presbyterian Healthways Prime Fitness Program
Presbyterian TruHearing
Presbyterian Magellan Healthcare – On to Better Health
Talkspace for Behavioral Health

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services is committed to equitable healthcare and exists to improve the health of patients, members and the communities we serve. We value diversity and inclusion and strive to treat all individuals with respect. We do not discriminate on the basis of race; color; ancestry; national origin (including limited English proficiency); citizenship; religion; sex (including pregnancy, childbirth or related medical conditions); marital status; sexual orientation; gender identity or expression; veteran status; military status; family care or medical leave status; age; physical or mental disability; medical condition; genetic information; ability to pay; or any other protected status. Presbyterian will provide reasonable accommodations and language access services for our patients, members, and workforce.

Presbyterian Healthcare Services:

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

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-5420, 1-855-592-7737, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated against you in another way, you can file a grievance with Presbyterian by calling 1-866-977-3021, TTY 711, fax (505) 923-5124, or **https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer**.

You can also file a complaint with these state agencies:

Address: Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta
Santa Fe, NM 87501

Phone: (505) 827-3811 or toll-free 1-855-427-5674

Online:* **www.osi.state.nm.us**

PRESBYTERIAN

Address: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501

Phone: (505) 490-4060 or toll-free 1-844-255-9210

Fax: (505) 490-4883

*To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit **https://www.nmag.gov/consumer-complaint-instructions.aspx**.

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

Address: U.S. Department of Health and Human Services200
Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

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

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

Aviso de no discriminación y accesibilidad

La ley prohíbe la discriminación

Presbyterian Healthcare Services se compromete a prestar servicios de atención médica equitativos y existe con el fin de mejorar la salud de los pacientes, de los asegurados y de las comunidades que servimos. Valoramos la diversidad y la inclusión y nos esforzamos por tratar a todos con respeto. No discriminamos por motivos de raza; color; linaje; origen nacional (incluso por dominio limitado del inglés); ciudadanía; religión; sexo (incluso por embarazos, partos o problemas médicos conexos); estado civil; orientación sexual; expresión o identidad de género; estado de veterano; estado militar; estado de ausencia familiar o médica; edad; discapacidad física o mental; estado médico; datos genéticos; capacidad de pago; o cualquier otro estado protegido. Presbyterian proporcionará adaptaciones razonables y servicios de acceso al idioma a nuestros pacientes, asegurados y fuerza laboral.

Presbyterian Healthcare Services:

- Presta servicios y ayuda a las personas con discapacidades para que se puedan comunicar efectivamente, por ejemplo:
    - Intérpretes calificados de lengua de señas
    - Información escrita en otros formatos (letra grande, grabaciones de audio, formatos electrónicos accesibles y otros formatos)
- Proporciona servicios gratuitos de acceso al idioma a las personas cuyo idioma principal no es inglés, por ejemplo:
    - Intérpretes calificados
    - Información escrita en otros idiomas

Si necesita alguno de esos servicios, llame al Centro de Servicio al Cliente de Presbyterian al (505) 923-5420, 1-855-592-7737, TTY 711.

Si cree que Presbyterian Healthcare Services no le ha proporcionado dichos servicios o si cree que le han discriminado de alguna otra manera, puede presentar una reclamación a Presbyterian si llama al 1-866-977-3021, TTY 711, fax (505) 923-5124, o **https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer**.

Además puede presentar una queja formal referente a los derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. electrónicamente en el portal de quejas de la Oficina de Derechos Civiles, que está a su disposición en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** o por correo o por teléfono al:

Además puede presentar queja a las agencias estatales siguientes:

Dirección: Managed Health Care Bureau
[Oficina de Atención Médica Administrada]
Office of Superintendent of Insurance
[Oficina del Superintendente de Seguros]

1120 Paseo De Peralta
Santa Fe, NM 87501

Teléfono: (505) 827-3811 o gratis al 1-855-427-5674

En línea:* **www.osi.state.nm.us**

Dirección: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501

Teléfono: (505) 490-4060 o gratis al 1-844-255-9210

Fax: (505) 490-4883

*Para llenar el Formulario de Queja del Consumidor o para bajar el formulario a su computadora, ya sea en inglés o español, visite **https://www.nmag.gov/consumer-complaint-instructions.aspx**.

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

Número de teléfono (gratuito): 1-800-368-1019, 800-537-7697 (TDD)

Los formularios de quejas están a su disposición en **http://www.hhs.gov/**.

Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 505-923-5420, 1-855-592-7737 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420，1-855-592-7737 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: 505-923-5420، 1-855-592-7737 رقم هاتف الصم والبكم (TTY: 711).
Korean	주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오 .
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420、1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).

PRESBYTERIAN

Trying to quit? You can do it!

Ready to try something new? You may have tried to quit in the past without success. Clickotine will give you to boost you need to quit—and quit for good.

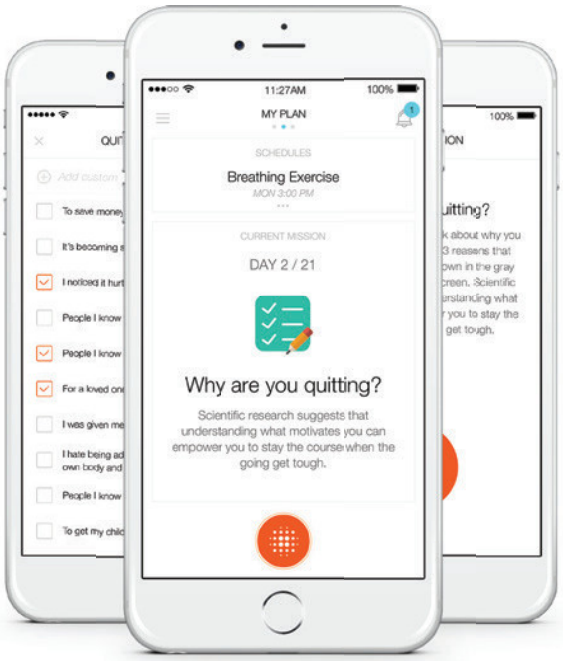
The challenging road to quitting

If you've been smoking for some time, you know how hard it can be to quit. In fact, nearly 70 percent of adult smokers want to stop. People trying to quit often feel alone in their daily struggle. The good news is that it's never too late to work on quitting, and once you do, your health will improve quickly and significantly.

Introducing the Clickotine mobile application

Clickotine is an innovative program that uses clinically-driven app technology to help you create and stick to a quit plan and overcome nicotine cravings. Based on clinical trials and data, Clickotine has a high success rate and includes these key features:

- ☑ **Personalized messaging:** Receive personal messages that keep you on track toward your quit goal.
- ☑ **Controlled breathing:** Monitor and control your breathing—an effective way to reduce nicotine withdrawal symptoms.
- ☑ **Real-time social support:** Post comments and share encouragement with others trying to quit.
- ☑ **Replacement distractions:** Get help diverting cravings to healthier actions.
- ☑ **Money saved:** Track how much money you've saved since your quit date—a powerful motivator for quitting.
- ☑ **Health recovered:** See how quitting has improved your health. As soon as you quit smoking, your body begins to recover.
- ☑ **Journaling:** Document how you're feeling during your quit journey. Not only can it help to relieve stress, it can also help you understand your smoking triggers, when you track your thoughts and feelings during your quit effort.



For more information on how to sign up, contact Customer Service at (505) 923-7787 or 1-855-261-7737 after July 1.

MPC041817 SERFF PBHP-131542927

PRESBYTERIAN Health Plan, Inc.

Magellan HEALTHCARE℠

Clickotine®

A Digital Therapeutics™ Program for Smoking Cessation

Finally, Personalized Help to Quit Smoking

Visit **www.clickotine.com** for details.

For more information on how to sign up, contact customer service at (505) 923-7787 or 1-855-261-7737 after July 1.

Partner Dashboard

Providing a web-based portal for partners enables observation of population trends, as well as detailed user-by-user data streams

Social Engagement

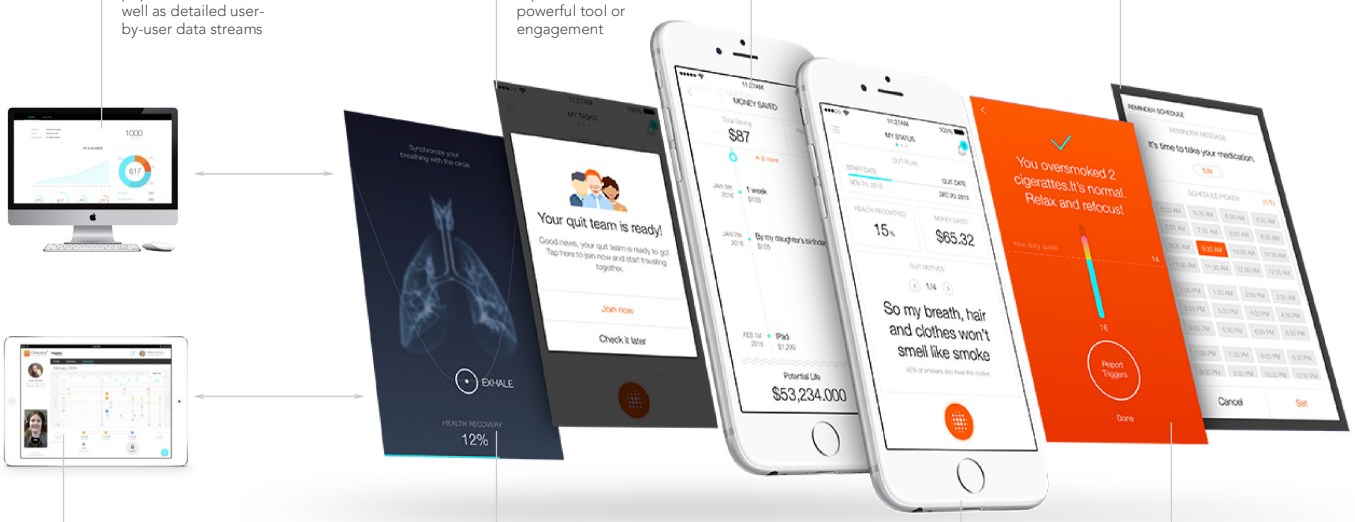
Real-life support from friends, family and community. Quitting with a small quit team is proven to be a powerful tool or engagement

Financial Incentives

Out-of-app incentives such as refunds & reimbursements provided by partners

Medication Adherence

Individualized reminder system to optimize use of effective treatment



Professional Caregiving

Real-time access to qualified professional caregivers, quit coaches & counselors

Controlled Breathing

Controlled, mindful breathing experiences coupled with multi-sensory stimuli

Personalized Messaging

Adaptive text messages tailored to user profile, and provides contextualized, personalized support and guidance

Digital Diversions

Timed and targeted strategies to cope with cravings, withdrawl symptoms & lapses

MPC041818

SERFF PBHP-131542927

PRESBYTERIAN Health Plan, Inc.

CLICK THERAPEUTICS™

Magellan HEALTHCARE℠

For technical assistance contact support

Call 877-352-5425

Monday - Friday 9AM - 6PM ET

support@clicktherapeutics.com

ANDROID APP ON Google play

Available on the App Store

Presbyterian Baby Benefits

Congratulations on your pregnancy!

Presbyterian offers a program that will help you have a healthy pregnancy and baby. You can enroll in the Presbyterian Baby Benefits prenatal program in one of these ways:

- Online at mypres.phs.org
- Call us at (505) 923-5017
- Email us at **PerformanceImp@phs.org**

When you join, you can earn prenatal and newborn reward cards to purchase healthy items. Join anytime during your pregnancy.

Follow these steps to earn your reward!

STEP 1 **Early Prenatal Visit:** Have your first prenatal (pre-birth) visit before week 13 of your pregnancy and earn a $25 gift card.

STEP 2 **Complete 10 Regular Prenatal Visits:** Go to at least 10 (or 80%) of your recommended prenatal visits and earn a $75 gift card to use towards healthy items.

STEP 3 **Postpartum Visits:** Have a visit for your health within 3-8 weeks (21-56 days) after your baby is born (postpartum) and earn a $50 gift card.

We will send you the gift card for each step as soon as you finish that step. To get your gift card, mail the certificate to us at the address below or you can also enter your visits online at mypres.phs.org.

Presbyterian Health Plan
PO Box 27489
Albuquerque, NM 87125

Please allow four to eight weeks to get your gift cards. Only visits after July, 1 2018 are included in program. Gift cards cannot be used to purchase alcohol, tobacco or firearms.

PRESBYTERIAN

MPC041816

The Importance of Prenatal and Postpartum Care

It is important to get prenatal care soon after you learn you are pregnant. Have your first prenatal visit between week 1 and week 12 of pregnancy.

Regular prenatal care is just as important as early prenatal care. You can usually expect to see your provider at these times:

- Weeks 4 to 28: About once a month
- Weeks 28 to 36: Two times a month
- Weeks 36 to delivery: Once a week
- Postpartum visit: Have a visit for your health 3-8 weeks (21 and 56 days) after you have your baby.

  At this visit, you can go over family planning and any other questions you might have about women's health and well-being.

If you have any questions, please contact the **Presbyterian Performance Improvement department**. You can leave a message any time. We will return calls Monday through Friday between 8 a.m. and 5 p.m.

Presbyterian Performance Improvement
Phone: (505) 923-5017
Voicemail only. Calls returned within 24 hours.
Toll-free: 1-866-634-2617
TTY: 711
Email: Performanceimp@phs.org

PBHP-131517502

PRESBYTERIAN
Health Plan, Inc.

Introducing a new benefit at no cost to you!

Learning how to cope with stress at work and at home can improve your overall well-being and help lower your healthcare costs.

You and family members living in your household can get up to three employee assistance visits per issue through The Solutions Group, a division of Presbyterian Healthcare Services.

Employee Assistance Program (EAP) services are short-term, confidential counseling sessions conducted by local licensed providers and can include:

- mediation services
- substance abuse assessments and referrals
- 24-hour emergency services
- support for supervisors and managers
- optional counseling via Video Visits
- referrals as needed

When faced with complex personal challenges, let our EAP providers help. To schedule an appointment with an EAP counselor, please call 1-866-254-3555 or (505) 254-3555.

Services provided by:

The Solutions Group

MPC091533

PRESBYTERIAN

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

Prime® Fitness FAQ

Presbyterian

What is Prime?

Prime is a fitness benefit offered through Tivity Health. Prime gives you access to a robust network of national, regional and local fitness and recreation centers, making it easy for you to get and stay active.

Which locations can I use?

Locations available for Presbyterian eligibles can be found at: **primemember.com**, under "Find A Fitness Center." You may search for the nearest Prime location by a specific address, city, state or ZIP code.

The Prime network features independents, nonprofits, regional chains and national providers. Our locations have a wide variety of amenities to suit your fitness goals.

Do I have to sign up for only one location or can I go to several?

Your Prime membership allows you to go to any participating location within the Prime network as many times as you wish. You can attend a group exercise class near your work, do some weight training near your home or use a pool at a Prime location if you're traveling. Just bring your Prime card or your Member ID to the location of your choice.

prime

I didn't receive my Prime card. Do I need one to visit a Prime gym?

If you haven't received your Prime card, you can print a temporary card from the website. Go to: **primemember.com**. Under "My Member Card" you can simply print your member card, take it to the location of your choice and enroll. If you're unable to print your card, just write down the 16-digit Member ID that appears on the screen and present it to the location of your choice.

Most locations will then issue you their own card to use whenever you visit. However, some locations ask that you use your Prime card when you visit. You can use the printed version of your card or request a new card if you have not received it. You may order a new card through "My Member Card." Simply click on the "Order a New Card" link, verify your mailing address and press "confirm." A Prime card will be sent to you in 10 business days.

I lost my Prime card. How do I order a new one?

If you've lost your Prime card, you can print a temporary card from the website. You may go to **primemember.com**. Under "My Member Card" you can simply print your member card, take it to the location of your choice and enroll. If you're unable to print your card, just write down the 16-digit Member ID that appears on the screen and present it to the location of your choice. Most locations will then issue you their own card to use whenever you visit.

However, if you've enrolled at a location that needs your Prime card whenever you visit, you can continue to use the printed version of the card or request a new card. You may order a new card through "My Member Card." Simply click on the "Order a New Card" link, verify your mailing address and press "confirm." A Prime card will be sent to you in 10 business days.

Who can I call for more information?

Tivity Health Customer Service can be reached at 1-877-238-6240, Monday-Friday, 8 a.m. to 8 p.m. ET.

PRESBYTERIAN

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

prime

PSBYPRME223FAQ0517
SERFF #PBHP-131031972

PRESBYTERIAN | TruHearing®

Enjoy Better Hearing and Comprehensive Care

Good hearing is important to your health. That's why Presbyterian Health Plan offers you a hearing aid benefit through TruHearing®. Hearing aids can be expensive—an average of $2,700 per aid[1]—but your benefit makes addressing hearing loss more affordable with **fees of $999 or less.**

Your Comprehensive Hearing Benefit Includes:

(See reverse for copayment details)

State-of-the-Art Technology

Experience the latest advances in hearing technology

- Enjoy natural, lifelike sound in virtually all listening situations
- Hear speech clearly, even in noisy environments
- Stream audio and phone calls directly to your ears from your smartphone[2]

Personalized Care

Receive expert care from our team of helpful professionals

- Guidance and assistance from a TruHearing hearing consultant
- Local, professional care from an accredited provider in your area
- A hearing exam plus three follow-up visits for fitting and adjustments

Help Along Your Way

Get started on the journey to better hearing with confidence

- A worry-free purchase with a 45-day trial and 3-year warranty
- 48 free batteries per aid included with non-rechargeable models
- Guides to help you adapt to your new hearing aids at TruHearing.com/GetStarted

Call TruHearing to learn more and schedule an appointment | Hours: 8am–8pm, Monday–Friday

1-833-731-4168 | TTY: 711

PRESBYTERIAN | TruHearing®

2020 Hearing Aid Coverage

Your plan covers up to two hearing aids per year.

Your Plan:	***TruHearing** Advanced* 32 Channels | 6 Programs Retail: ~~$2,445~~/aid	***TruHearing** Premium** 48 Channels | 6 Programs Retail: ~~$3,125~~/aid	***Routine Exam*** In-Network[3]
Presbyterian Health Plan	**$699** fee/aid	**$999** fee/aid	**$45** exam fee

*Rechargeable battery option is available on the TruHearing Premium RIC Li, Slim RIC Li, Standard BTE Li, and CROS Li styles for an additional **$75** per hearing aid. Slim RIC Li only available with rechargeable upgrade.

→ Call TruHearing to learn more and schedule an appointment

1-833-731-4168 | For TTY, dial 711

Hours: 8am–8pm, Monday–Friday

[1] Based on a 2018 third-party survey of nationwide provider and manufacturer retail pricing.
[2] Smartphone-compatible hearing aids connect directly to iPhone®, iPad®, and iPod® Touch devices. Connectivity also available to many Android® phones with use of an accessory.
[3] Must be performed by a TruHearing network provider.

This benefit does not generate a claim or an Evidence of Benefit summary.

Services do not apply to deductibles or out-of-pocket maximums.

All exams and equipment must be purchased from a TruHearing provider to qualify for the benefits.

 Three follow-up visits must be used within one year after the date of initial purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant. PRESB_COM_S_F_0719

PRESBYTERIAN

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

Magellan HEALTHCARE℠

On To Better Health

Self-help tools and resources at your fingertips

On to Better Health gives you online access to self-help tools and resources proven to help people get better and feel better. Complete guided therapy programs to change unhelpful thoughts and behaviors. Read health and wellness articles. Chat online with a clinician, or schedule a virtual therapy session. All of the tools and resources are easy to use, confidential and available 24/7!*

On To Better Health helps you:

- Identify your needs – by answering a few questions, a personal health plan is created just for you.
- Get help through digital cognitive behavioral therapy for common challenges such as:
  - Insomnia
  - Depression
  - Anxiety
  - Obsessions orcompulsions
  - Alcohol or substance use
  - Chronic pain
- Read helpful tips and articles based on your interests and health needs.
- Chat with a clinician about goals and progress.
- Schedule an online therapy session with a licensed therapist or psychiatrist.

To access the programs:

- Go to **www.ontobetterhealth.com/php** and sign in to your account.
- View your list of recommended programs.
- Click the *Launch Program* button to start a module.
- Browse through thousands of library articles, resources and self-assessments.

Sometimes it's hard to find time for yourself or get help when you do find time.
***On To Better Health** is there when and where you want it. Get started today!*

**You may not have access to all of the features. IF YOU HAVE A MEDICAL EMERGENCY, IMMEDIATELY CALL 911 TO GET PROMPT MEDICAL ATTENTION. The information on this website is not to be construed as medical advice or recommendations or as as ubstitute for professional medical advice and is not a substitute for consultation with a qualified physician. You should consult with a physician or other healthcare professional for any healthcare concerns including without limitation before you take any prescription or over the counter drugs.The information provided on this website does not replace the relationship that exists between patients and their physicians or other healthcare professionals. Never disregard your physician's or other healthcare provider's advice or delay seeking their advice as a result of anything you have read on this website. All materials and information contained herein is provided "as is" and is for educational purposes only. Reliance on any information provided on this website or otherwise from Magellan Health, Inc. and its subsidiaries and affiliates ("Magellan") is solely at your own risk.*

Presbyterian Senior Care (HMO)/(HMO-POS) and Presbyterian MediCare PPO are Medicare Advantage plans with a Medicare contract. Enrollment in Presbyterian Senior Care (HMO)/(HMO-POS) and Presbyterian MediCare PPO depends on contract renewal. Presbyterian Dual Plus is an HMO Special Needs Plan (SNP) with a Medicare contract and a contract with the State of New Mexico Human Services Department Medicaid program. Enrollment in Presbyterian Dual Plus (HMO SNP) depends on contract renewal.

Presbyterian complies with applicable Federal civil rights laws and does not discriminate on the basis of color, national origin, age, disabiliity, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia linguística. Llame al 505-923-5420. 1-855-592-7737 (TTY: 711). Díí baa akó nínízín: Díí saad bee yánítti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh éí ná hóló, koji hódíílnih 505-923-5420, 1-855-592-7737 (TTY: 711).

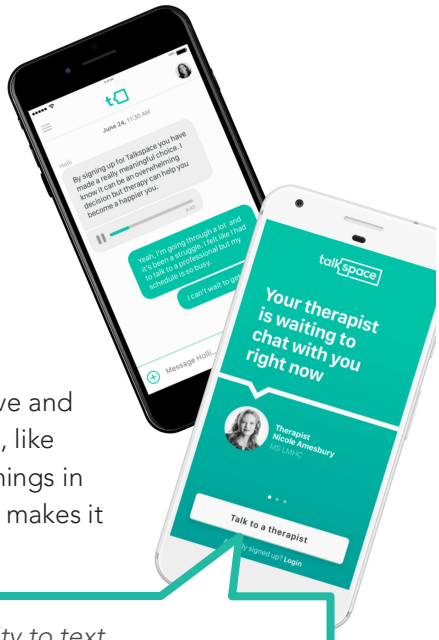
MagellanHealthcare.com
H-F1012 (8/18)VCS-MEM-0001-18

Y0055_MPC041905_NSR_C_04122019

PBHP-131766006 (IPlan); PBHP-131766079 (PHP); PBHP-131766082 (PIC)

Talkspace for Behavioral Health

Mind Your Mental Health with Messaging Therapy
A new solution for emotional wellbeing



Mental health affects every aspect of our lives. When you feel good, you are more productive and happier, and you can handle life with more ease. When your mental health is out of balance, like when you are stressed or worried, it can keep you from doing and enjoying the important things in your life. Just like you take care of your body, you need to take care of your mind. Magellan makes it easy to do that with messaging therapy from Talkspace.

What is messaging therapy?

Messaging therapy enables you to find and communicate with a therapist anytime via your web browser or the Talkspace secure mobile app. No more having to wait months for an appointment or needing time off to visit a therapist in a busy office. With Talkspace, you can participate in therapy at a time and place that is convenient for you.

Talkspace therapists have a proven track record of using messaging therapy to help with a variety of conditions including anxiety, depression, substance abuse, panic and bipolar disorders, all of which can be debilitating if not treated. They can also help manage the unique challenges some people face, like being a single parent, a veteran or a member of the LGBT community.

How it works

With Talkspace there are no appointments. You can send your therapist a message whenever you need to, and they will engage with you daily, five days a week. With a network of over 2,000 trained, licensed therapists, Talkspace will connect you with a dedicated therapist based on your needs, preferences, therapist availability and expertise. You can contact your therapist through unlimited text, video and audio messages.

"I absolutely love the ability to text, video message, or voice message whenever I need support. The growth I have been able to accomplish in less than a year is far more than I ever was able to get from visiting a therapist in person for years on end." – Amanda, Talkspace User

What's in it for you?

For some people, traditional in-person therapy can be intimidating, difficult to arrange, time consuming and expensive. For others, a lack of appointment availability or coverage in remote areas may cause access difficulties.

With Talkspace you can:

- Engage with a therapist the same day that help is needed, not weeks later
- Get matched to a therapist based on your unique needs
- Develop a one-on-one relationship with the same therapist throughout your engagement
- Live a happier, healthier life

For more information on how to sign up, contact customer service at (505) 923-7787 or 1-855-261-7737 after July 1.

talkspace

PRESBYTERIAN
Health Plan, Inc.

MPC041819

PBHP-131542927