Presbyterian Health Plan

Summary Plan Description

STATE OF NEW MEXICO

HMO Medical Plan
HWH10002 and HWH10041

EFFECTIVE: January 1, 2019

Offered by the State of New Mexico
Administered by Presbyterian Health Plan

MPC011907

Welcome

This *Summary Plan Description* describes your group medical benefits. The State of New Mexico 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 January 1, 2019. 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 State of New Mexico 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 benefits decisions for you and your family.

Very truly yours,

General Services Department, Risk Management Division (GSD/RMD)

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SUMMARY OF BENEFITS

The following are the Highlights of the HMO administered by Presbyterian Health Plan, Inc. (PHP) for State of New Mexico employees Statewide. These benefits are effective 1/1/19 through 12/31/19. The specific terms of coverage, limitations and exclusions are detailed in Sections 2, 4, and 5 of the Summary Plan Description

BENEFITS	**NATIONAL HMO PLAN**	
	Benefit Highlights	***In-network and out-of-state National PPO Network/ Provider Care***
N	Copayments/Co-insurance vary depending on service; see below	
	Member deductible (Calendar Year) Single Two-Party Family	 $ 350 $ 700 $ 1,050
	Out-of-Pocket Maximum (Calendar Year) Includes medical and Rx cost sharing Single Two-Party Family	 $3,750 $7,500 $11,250
	Lifetime maximum	Unlimited (Certain services are subject to Calendar Year and/or lifetime maximums or are limited per condition.)
Physician Services	Office visit Primary/Gyn care Video visits Specialty care	 $25 office visit Copayment[5] $0 Copayment[5] $45 office visit Copayment[5]
	On-campus student health center	$25 Copayment per visit[5]
	Preventive services Routine physicals Well child care including vision and hearing screening (through age 26) Immunizations Adult wellness Health education programs	 No Copayment[5] No Copayment[5] No Copayment[5] No Copayment[5] Fees Vary (based on service)
	Women's Preventive Services Contraceptive Methods • Intrauterine Devices (IUD) • Hormone Contraceptive Injections • Inserted Contraceptive Devices • Implanted Contraceptive Devices Breastfeeding support, supplies and counseling (for one year after delivery)	No Copayment
	Laboratory	20%
	X-ray	20%
	Allergy testing and treatment	$45 office visit Copayment[5]
	Allergy injections by a nurse	No Copayment[5]
	Allergy extract preparation	No Copayment

SUMMARY OF BENEFITS

Hospital Services	Hospitalization (includes room and board, Inpatient Physician care – Physician visits, surgeon, and anesthesiologist)[3]	$600 Copayment per Admission
Hospital Services (continued)	Inpatient rehabilitation services[3]	$ 600 Copayment per Admission
	Laboratory	20%
	X-ray	20%
	MRI/PET Scans/CT Scans[3]	20% Co-insurance up to a maximum of $200 per test per day
	Hospital Observation Services (no Admission)	$250 Copayment
	Surgery – Outpatient (no Hospital Admission) – Facility claim only	20% Co-insurance
Maternity Services	Physician/midwife services (delivery, prenatal/postnatal care) Note: Copayment does not include laboratory or x-ray services.	$25 Copayment – initial visit only, all other visits no Copayment
	Genetic testing and counseling[3]	Copayment based on place of service
	Hospital Admission[3]	$500 Copayment per pregnancy
	Routine nursery care for newborns	No Copayment
Emergency Services	Emergency room visit[2] Urgent Care center Ambulance[1] Ground transportation Air ambulance	$ 275 Copayment $ 55 Copayment $30 Copayment per trip $100 Copayment per trip
Mental Health	Outpatient services Inpatient services[3] Partial Hospitalization[3] Residential Treatment Center[3] (limited to 60 days/ Calendar Year; must be Medically Necessary.)	$25 office visit Copayment[5] $500 Copayment per Admission $250 Copayment per Admission $500 Copayment per Admission
Substance Abuse	Outpatient services[3] Acute Inpatient Hospital services [3] Partial Hospitalization [3] Intensive Outpatient (non-Step Down)[3] Residential Treatment Center[3] (limited to 60 days/ Calendar Year; must be Medically Necessary.)	$25 office visit Copayment[5] $500 Copayment per Admission $250 Copayment per Admission $25 Copayment per visit[5] $500 Copayment per Admission
Autism Spectrum Disorder (Habilitative)	PCP[3,] Specialist[3] Outpatient Physical Therapy[3] Outpatient Speech Therapy[3] Applied Behavioral Analysis (ABA) ***Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school.***	$25 office visit Copayment[5] $45 office visit Copayment[5] $45 office visit Copayment[5] $45 office visit Copayment[5] $45 office visit Copayment[5]
Other Services	Biofeedback (for specified medical conditions only)	$45 office visit Copayment[5]
	Cardiac or pulmonary rehabilitation	$45 office visit Copayment[5]
	Chemotherapy and/or radiation therapy	No Copayment in Physician's office
	Chiropractic (Combined annual limit of 25 visits)[4] Acupuncture (Combined annual limit of 25 visits)[4] Naprapathic Services ($500 Calendar Year max)[4]	$50 office visit Copayment[5] $ 50 office visit Copayment[5] $ 55 office visit Copayment[5]
	Dental services (for specified medical conditions only) Inpatient[3] Outpatient	 $ 600 Copayment per Admission $45 office visit Copayment[5]
	Dialysis	No Copayment

Other Services (cont'd)	Durable Medical Equipment, orthotics, prosthetics and appliances[3]	23%
	Injectable drugs received in the office[3] If billed in conjunction with an office visit If provided by a nurse and no office visit is billed	Included in office visit Copayment based on the location of the services (PCP, Specialist, etc.) No Copayment
	Home health care[3]	$45 Physician Copayment[5]; no Copayment for nursing services
	Hearing Aids (to include repair, replacement, and associated testing)	Plan pays 100% up to a maximum of $2,500 per hearing impaired ear every 36 months[5]
	Hospice[3] Bereavement counseling (limited to 3 sessions during the Hospice benefit period) Respite care (lifetime maximum of 2 sessions of up to 10 days for each Hospice benefit period)	No Copayment[5]
	Infertility related services (only limited services covered)	Copayment based on services
	Physical, occupational and speech therapy	$45 office visit Copayment[5]
	Skilled nursing facility (Admission Copayment waived if readmitted within 15 days)[3]	$ 600Copayment per Admission
	Sleep disorder studies Inpatient[3] Home/Sleep lab (2 nights)	 $ 600Copayment per Admission 20% Co-insurance
	Smoking cessation	50% Co-insurance
	Surgical services Inpatient Outpatient In-Office PCP Specialist	 Covered as part of Hospital Admission 20% Co-insurance (Facility claim only) Included in PCP office visit Copayment[5] $45 office visit Copayment[5]
	Reconstructive Surgery[3] Inpatient Outpatient	 $ 600Copayment per Admission 20% Co-insurance (Facility claim only)
	Weight loss programs (Morbid Obesity treatment only) Inpatient[3] Outpatient	 $600 Copayment per Admission $45 office visit Copayment[5]
Transplants[3] *(No Lifetime Maximum)*	Coverage for human organ transplants (refer to Sections 4 and 5 for details on transplant coverage)	Copayments based on place of service
Prescription Drugs	**Administered by Express Scripts.** Call Express Scripts at **1-800-743-1720.**	

[1] *Ambulance Copayment is waived if transportation is Medically Necessary and results in a Hospital Admission.*

[2] *The $275 emergency care is waived if a Hospital Admission results. Then, the Hospital Admission Copayment applies. Copay is for the ER visit only, other services are subject to deductible and coinsurance.*

[3] ***Prior Authorization*** *may be required. See Section 2 for Prior Authorization requirements and potential penalties.*
[4] *This benefit includes an annual maximum payment, annual visit limitation, lifetime visit limitation and/or lifetime maximum payment. Refer to Sections 2 and 4 of this booklet.*
[5] *Not subject to the Deductible*

Health Management

PHP provides members a number of tools to help better manage all health conditions, including:

- Direct access to medical advice any time, day or night through PresRN Nurse Advice Line – 1-866-221-9679.
- Help with managing chronic conditions through Presbyterian Health Solutions program – (505) 923-5487 or 1-800-841-9705.
- Useful diabetes education and support through our Certified Diabetes Educators. These resources are available through "Find a Doctor" on www.phs.org.

The State of New Mexico provides group health care coverage through the Health Maintenance Organization Plan (Plan) administered by Presbyterian Health Plan, Inc.

SECTION 1 - INTRODUCTION

The State of New Mexico provides group health care coverage through the HMO-type Medical Plan (Plan) administered by Presbyterian Health Plan, Inc. (PHP).

You may select an In-network Primary Care Physician (PCP) to direct your health care 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 Web Site (https://www.phs.org/doctors-services/Pages/find-a-doctor.aspx) when selecting your In-network (PCP). You can also obtain covered services from out-of-state National PPO Network Provider /when you are outside of New Mexico through our National PPO Network Providers Your deductible, Copayment and/or Co-insurance will be the same as if you received the services from an In-network Provider. However, because some National PPO Network Providers are not considered "In-network Providers", there are some important differences that will be noted in the next section and throughout the document. To find a provider through our National PPO Network Providers please refer to the website.

If you obtain services from an In-network or an out-of-state National PPO Network Provider/Practitioner, you will not have to file any claims. In-network Providers, as well as out-of-state National PPO Network providers are responsible for filing all claims to PHP.

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

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

- Providers are Physicians, Hospitals, and other Health Care Professionals or facilities that provide Health Care Services.
- In-network PCP's and In-network Providers have contractual agreements with PHP that allow lower out-of-pocket expenses and additional benefits for covered persons.
- PHP has arranged to provide additional coverage with an out-of-state National PPO Network Providers when you obtain services outside of New Mexico.

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) 923-5600**, or toll free at **1-888-275-7737**. TTY users may call **1-877-298-7407**. It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

SECTION 2 – HOW THE PLAN WORKS

Your Group healthcare plan is an HMO Plan whereby you obtain all routine covered services from In-network Providers/Practitioners within the PHP Provider network or from our National PPO Network Providers outside of New Mexico.

In-network Providers

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

In-network OB/GYNs can be seen. This benefit, called Open Access, allows female Members to see their OB/GYN for care related to pregnancy or any gynecological condition. The plan does not require prior authorization or a referral for a female patient to see a participating provider specializing in OB/GYN care. OB/GYN providers are allowed to directly refer for or order OB/GYN related items and services without approval of another provider including your PCP.

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

National PPO Network Providers/

You can also obtain covered services outside of New Mexico from National PPO Network Providers. Your deductible, Copayment and/or Co-insurance will be the same as if you received the services from an In-network Provider. You can contact a Presbyterian Customer Service Center representative to help you locate an out-of-state National PPO Network provider. However, National PPO Network Providers are not considered "In-network Providers". If a covered service requires Prior Authorization, you are responsible to obtain that Prior Authorization before obtaining that covered service from a National PPO Network Provider. If you fail to obtain Prior Authorization when required, you will be responsible for a $250 penalty for covered services, in addition to Copayments, Deductibles, and/or Co-insurance as listed in the *Summary of Benefits*
You will not have any claims to file or papers to fill out in order to be reimbursed for medical services obtained from In-network Providers and an out-of-state National PPO Network Providers. Your In-network Provider or out-of-state National PPO Network 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*.

Out-of-network Providers/Practitioners

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

SECTION 2 – HOW THE PLAN WORKS

HOW TO ACCESS CARE

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

You may choose to obtain PCP services from an out-of-state National PPO Network provider. If you chose this option, no PCP data will appear on your ID Card. If you decide to obtain PCP services from an out-of-state National PPO Network provider, you will have to manage more of your health care. National PPO Network providers are not required to utilize In-network Providers/Practitioners, In-network Hospitals or facilities, or other out-of-state National PPO Network providers or facilities for laboratory tests, x-rays or any other covered service Therefore, if you choose to obtain services from a National PPO Network provider and they request laboratory tests, x-rays, etc, or refer you to another provider/specialist, it is your responsibility to ensure the provider, practitioner, or facility providing covered services is an In-network or an out-of-state National PPO Network Provider or facility. Otherwise, the services may not be covered and your claim may be denied.

WHAT IS PRIOR AUTHORIZATION?

Prior Authorization can provide you with assurance that, when you are using the Plan, you are being treated in the most efficient and appropriate healthcare setting. It will also help manage the rising costs of health care. Your participation is essential. Together, we can make Prior Authorization an effective program.

If you obtain services from an In-network Provider, the PHP Health Services Department staff will ask your In-network PCP/Specialist for information about your medical condition, the proposed treatment plan and the estimated length of stay, if hospitalization is required. The Health Services Department staff will evaluate the information and notify your PCP or Specialist (usually at the time of the call) if the proposed treatment or hospitalization is approved. Prior Authorization has been completed when your In-network PCP/Specialist has been told that the proposed services are approved. Payment is made as explained in the *Summary of Benefits* and in "Covered Services".

If you obtain services from an out-of-state National PPO Network Provider, you will have to contact PHP to obtain Prior Authorization, when required. You should discuss the need for Prior Authorization with your out-of-state National PPO Network Provider. However, it will remain your responsibility to obtain Prior Authorization, when required. Failure to do so may result a $250 penalty, in addition to the Copayment, Deductible and/or Co-insurance listed on the *Summary of Benefits*.

The Prior Authorization requirements affect whether the Plan pays for your Covered Services. However, Prior Authorization does not deny your right to be admitted to any Hospital.
Important: If you have Two-Party or Family Coverage, Prior Authorization requirements apply to your family Members who are also covered persons.

WHAT PROCEDURES REQUIRE PRIOR AUTHORIZATION?

Prior Authorization is required for many services. If you obtain services from an In-network Provider, they will obtain Prior Authorization. If you obtain services from an out-of-state MP/PHCS Provider, you are responsible for obtaining Prior Authorization (when required) prior to obtaining services.

Services of an Out-of-network Provider will **not** be covered without Prior Authorization. If you are obtaining services from an Out-of-network Provider, it is your responsibility to verify that Prior Authorization has been obtained before any services are obtained. (The only exception is for emergency or urgent care, or care in a Student Health Center.)

PRIOR AUTHORIZATION – INPATIENT

If an In-network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, that In-network Provider is responsible for any Prior Authorization requirement for Inpatient Admissions. If an out-of-state National PPO Network Provider recommends you be admitted as an Inpatient to a Hospital treatment facility, it is your responsibility to obtain Prior Authorization prior to being admitted.

If there has been no Prior Authorization, you are Hospitalized, and PHP determines that the Admission was for a covered service but hospitalization was **not** Medically Necessary, **no** benefits are paid for Inpatient room and board charges and these expenses do **not** apply toward the out-of-pocket maximum provision. Other Covered Services are paid as explained in the *Summary of Benefits* and Section 4. If the Admission is **not** for a covered service, **no** payment is made.

Note:
All Inpatient behavioral health and Alcohol and/or Substance Abuse services require Prior Authorization from the PHP Behavioral Health Department (1-800-453-4347). Services without Prior Authorization will **not** be covered. For emergencies, PHP Behavioral Health Department must be notified by the end of the next business day or benefits may be denied.

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

Important: If you have Two-Party or Family Coverage, Prior Authorization requirements apply to your family Members, too.

PRIOR AUTHORIZATION FOR OTHER MEDICAL SERVICES

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

In addition to Prior Authorization for all Inpatient services, Prior Authorization is required for the following services.

- Bone growth stimulators;
- Cancer Clinical Trials as specified in Section 4;
- Durable Medical Equipment, orthotic and prosthetic devices over $1,000 (also see the Express Scripts drug coverage booklet or call them at 1-800-743-1720 number);
- Durable Medical Equipment and Supplies purchased from Vendors;
- Podiatric and Orthopedic Appliances;
- Rentals;
- Home health care;
- Hospice;
- Hospital Admissions;
- Certain injectables received in the Provider's office;
- Investigational or Experimental Services;
- Magnetic Resonance Imaging (MRI);
- Computer Axial Tomography (CAT/CT)
- Mental Health (Inpatient);
- Medical Supplies greater than $1,000;
- Morbid Obesity;
- Services from Out-of-network Providers (excluding out-of-state National PPO Network providers), except for injuries, emergencies, a need for Urgent Care or the use of a Student Health Center;
- Orthotics and Prosthetics;
- Positron Emission Tomography (PET) Scans;
- Reconstructive Surgery;
- Repair or replacement of non-rental DME;
- Residential Treatment Centers;
- Selected Surgical Procedures;
- Skilled Nursing facilities;
- Substance Abuse Services; and
- Transplants.

Note: In-network Providers request Prior Authorizations. Discuss the need for Prior Authorizations with your In-network Provider before obtaining any of the services listed above. If you obtain any of these services from an out-of-state National PPO Network provider, you will have to obtain Prior Authorization from PHP prior to obtaining services. If you fail to obtain Prior

Authorization, you will be responsible for a $250 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Co-insurance as listed in the *Summary of Benefits*.

CASE MANAGEMENT PROGRAM

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

TRANSITION OF CARE

If you are a new Member and are in an ongoing course of treatment with an Out-of-network Provider, you will be allowed to continue receiving care from this Provider for a transitional period of time (usually not to exceed 90 days). Similarly, if you are in an ongoing course of treatment with an In-network Provider and that Provider becomes an Out-of-network Provider, you will be allowed to continue care from this Provider for a transitional period of time. Application must be made within 30 days of the event. Please contact PHP's Health Services Department at 1-888-275-7737 or (505) 923-5600, for further information on Transition of Care.

COST SHARING FEATURES

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

Copay/Copayment

For most Covered Services, you pay a Copay/Copayment and the Plan pays the remainder. The Copayment is stated either as a set dollar or percentage amount, or a Co-insurance percentage. See the *Summary of Benefits* for all applicable Copayments.

Hospital Admission – Medical

The per-Admission Copayment amount is listed in the *Summary of Benefits*. In the event you are hospitalized and subsequently transferred within the facility, no new Copayment will be required.

Hospital Admission – Mental Health

The per-Admission Copayment amount is listed in the *Summary of Benefits*. In the event you are hospitalized and subsequently transferred within the facility, no new Copayment will be required.

Note:
In-network and National PPO Network Providers accept the PHP Negotiated Fee-for-Service as their maximum fee. You pay only the Copayment and any non-covered expenses.

If you are re-admitted (inpatient) to the same hospital or inpatient medical facility within 15 days of being discharged and the diagnosis is the same or similar, this may be considered one inpatient stay and you may be responsible for only one inpatient Copayment. If this situation occurs, please contact Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at (505) 923-5600, or toll free at 1-888-275-7737, after you have been discharged the second time.

Co-insurance

This is the amount of the Covered health care expense that is partially paid by the Plan and partially paid by you on a percentage basis. This Co-insurance is in addition to the Calendar Year Deductible you are responsible for and continues to be your responsibility after the Calendar Year Deductible is met. See the *Summary of Benefits* for Co-insurance amounts.

Calendar Year Deductible

Some services are subject to a Calendar Year Deductible. The amount of your Calendar Year Deductible can be found in the *Summary of Benefits*. The *Summary of Benefits* also illustrates the Two-Party and family Deductible. This Deductible must be paid by you each Calendar Year toward Covered Services **before** health benefits for that Member will be paid by the Plan (except for those services listed as not subject to the Deductible on the *Summary of Benefits*).

For single Coverage, the annual Deductible requirement is fulfilled when the Member meets the individual Deductible, listed in the Schedule of Benefits, during the Calendar Year.

For two-party coverage, the annual Deductible can be satisfied by any combination of the family members. No one member can contribute more than the individual deductible amount toward the two-party deductible. Once a member meets their individual amount their deductible is considered met.

For Family coverage, the annual Deductible can be satisfied by any combination of the family members. No one member can contribute more than the individual deductible amount toward the family deductible. Once a member meets their individual amount their deductible is considered met. If a Member's individual Deductible is met, no more charges incurred by that Member may be used to satisfy the family Deductible.

The deductible includes some medical Copayments and prescription Copayments.

Calendar Year Out-of-Pocket Maximum

The Plan includes a Calendar Year out-of-pocket maximum amount to protect you from catastrophic healthcare expenses. After your out-of-pocket maximum is reached, the Plan pays 100% for Covered Services for the remainder of that Calendar Year, up to the maximum benefit amounts. See the *Summary of Benefits* for the out-of-pocket maximum amounts.

For single Coverage, the Annual Out-of-Pocket Maximum requirement is fulfilled when the Member meets the individual Out-of-Pocket Maximum, listed in the Schedule of Benefits**,** during the Calendar Year.

For double or family Coverage, with two enrolled Members, the Annual Out-of-Pocket Maximum requirement is fulfilled when both Covered Members have each met their applicable Individual Out-of-Pocket Maximum listed, in the Schedule of Benefits, during the Calendar Year.

For family Coverage, with three or more enrolled Members, the Family Out-of-Pocket Maximum requirement is fulfilled when any three Covered Members have each met their applicable Individual Out-of-Pocket Maximum, listed in the Schedule of Benefits, during the Calendar Year.

The out-of-pocket maximum includes all Copayments, prescription Copayments, Co-insurance and Deductibles. The out-of-pocket maximum does **not** include penalty amounts, non-covered charges, any amounts over Reasonable and Customary charges. If any one family Member's out-of-pocket amount equals the individual out-of-pocket Maximum, the out-of-pocket maximum for that Member is met.

Calendar Year Family Out-of-Pocket Limit

An entire family meets the applicable out-of-pocket limit when three family Members each satisfy the individual out-of-pocket limit as indicated on the *Summary of Benefits*. The *Summary of Benefits* also illustrates the Two-Party and family out-of-pocket limits. If a Member's individual out-of-pocket is met, no more charges incurred by that Member may be used to satisfy the family out-of-pocket.

The out-of-pocket maximum is listed in the *Summary of Benefits* and includes all the Copayments, prescription Copayments, Co-insurance, and Deductible. The out-of-pocket Maximum does **not** include penalty amounts, non-covered charges, any amounts over Reasonable and Customary charges.

If the Plan's out-of-pocket maximums change during the year, then the new amounts are in effect during that same Calendar Year. This means that if you had met your lower out-of-pocket maximums and then this Plan changes to higher out-of-pocket maximums, you do not continue to receive the 100 percent payment until the increase in the out-of-pocket maximum is met during the higher out-of-pocket period. If your out-of-pocket maximum amounts decrease, you do not receive a refund for any out-of-pocket amounts applied during the higher out-of-pocket period.

MAXIMUM BENEFITS

There is no lifetime maximum payment under the Plan. However, certain benefits specifically limited and described in the *Summary of Benefits* and Section 5 have maximum limits per Calendar Year.

MEDICAL NECESSITY

The Plan helps pay healthcare expenses that are Medically Necessary and for those routine services specifically covered in this Summary Plan Description (SPD). **No** benefit is available for any expense that is **not** Medically Necessary, unless it is for a routine service specifically covered in this SPD.

Medical Necessity or Medically Necessary means Health Care Services determined by a Provider, in consultation with the healthcare insurer, to be appropriate or necessary, according to any applicable generally accepted principles of good medical practice and practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and 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 or Mental Health condition, illness, injury, or disease.

PHP determines whether a healthcare service or supply is Medically Necessary, and, therefore, whether the expense is covered. (**Note:** If you disagree with PHP's decision regarding the Medical Necessity of any item or service, you may file a Grievance or complaint. You may also request an external review of the PHP decision at any time. See "Grievance Procedures" in Section 7.) The fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it Medically Necessary or make the expense a covered service, even though it is not specifically listed as an exclusion.

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 Special Investigative Unit (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: PHPFrau@phs.org
- File a Suspected Fraud and Abuse Report online at 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 records
- Use of unlicensed 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 an ineligible Dependent to the plan
- "Loaning" or using another'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
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
You may email the Bureau at: stopfraud@state.nm.us

New Mexico Medical Assistance Division for Medicaid Fraud
Telephone: toll-free 1-888-997-2583
NMMedicaidFraud@state.nm.us

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

The United States Office of Personnel Management (OPM)
Office of the Inspector General Fraud Hotline
1900 E Street NW, Room #6400
Washington, DC 20415-0001
Telephone: toll-free 1-877-499-7295
http://oig.hhs.gov/fraud/report-fraud

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

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

EMPLOYEE ELIGIBILITY

- An eligible employee includes anyone hired as classified, Governor-exempt, probationary, temporary, term or hourly, scheduled to work an average of at least 20 hours per week over the course of a pay period and meets the prospective employers waiting period. Elected Officials, if part of the State or a participating LPB, are considered eligible and do not need to meet the work schedule of at least 20 hours per week. Independent contractors are *not* eligible under the State benefit plan.

  - Temporary employees who extend to 90 days may be eligible for coverage if they are scheduled to work at least 20 hours per week. Employees will be eligible for benefits, as long as the employee has met the required eligibility waiting period.

  - Dual coverage is not allowed. If both an employee and their spouse/domestic partner are eligible employees, they cannot enroll each other as a spouse/domestic partner, nor can they both cover their children. The only exception is dependent life for employee/spouse/domestic partner. If both eligible employees seek to enroll their spouse/domestic partner and/or dependents, the enrollment will be rejected and forms returned for proper election.

DEPENDENT ELIGIBILITY

- **Dual coverage is not allowed**. An eligible dependent cannot be covered by more than one employee participating in the Plan.
  - An eligible employee's dependents are eligible to be covered under the State's Group Benefits Plan as follows:
  - An eligible employee's lawful spouse may be enrolled as a dependent after presenting a marriage certificate or other documentation which establishes that the couple entered into a valid common-law marriage in another jurisdiction. Same sex marriage certificates from states that legally recognize same sex spouses (currently including NM) shall be treated as an employee & spouse, with the option of pre-tax premiums for employees only.
  - An eligible employee's domestic partner may be enrolled as a dependent upon submission of executed Affidavits of Domestic Partnership. Please see Domestic Partner section for further information.
    - NOTE: According to Federal IRS Guidelines, premiums for domestic partners/child(ren) cannot be taken on a pre-tax basis.
  - An eligible employee's children and legal dependents under the age of twenty-six (26) may be enrolled as dependents upon submission of a birth certificate, legal adoption papers, and/or guardianship order.

- Disabled legal dependents that are incapable of self-support are eligible for medical, dental and vision coverage beyond age twenty-six (26). Evidence of legal guardianship and disability is required upon enrollment.
- A court order directing that an employee and/or employee's dependent provide insurance for someone else does not require the State to grant eligibility. Individual coverage may need to be purchased separately. NOTE: A "Power Of Attorney" is not considered a court order to establish State Plan eligibility or otherwise extend coverage under the State Plan.
- If an employee's spouse has step-children from a previous marriage, and neither the employee nor spouse has adopted them or obtained legal guardianship, the step-children are not eligible for coverage.

To receive benefits under this Plan, you and your eligible Dependents must reside within the Plan's authorized service area. However, please review the following as it relates to Dependents who live both in and/or out of the authorized service area, who are also eligible for benefits.

- If the Dependent attends school in any PHP service area, services may either be received through the PCP or at the Student Health Center.
- If the Dependent attends school outside the service area, services may be received at the Student Health Center. Services are limited to Medically Necessary services received either from the Student Health Center or the nearest appropriate facility where emergency medical treatment can be secured. While the Dependent is within the service area, services must be received through the PCP.
- If the Dependent is eligible for coverage under this Plan as the result of a court order and the Dependent does not live within the service area:
  - You or the covered Dependent is responsible for obtaining any required **Prior Authorizations** from the Plan. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-network National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.
  - Medically necessary Covered Services provided by Out-of-network Providers will be reimbursed less the appropriate Copayment up to the Reasonable and Customary Charge. You and/or your Dependent will be responsible for paying any amounts over Reasonable and Customary Charges or for services **not covered** under this Plan.

During initial enrollment, you must provide proof of incapacity and dependency to your agency group representative. Thereafter, proof incapacity and dependency may be requested periodically by the Claim Administrator.

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

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

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.

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 Calendar Year – from January 1 to December 31. Each year you will have an opportunity to change your group health plan elections. The change is effective the following January 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 Two-Party 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.

- If you are an eligible employee paid on a biweekly basis, you are eligible for this Plan on the first day of the third full pay period following your date of employment.
- If you are an eligible employee paid on a monthly basis, you are eligible for this Plan on the first day of the month coinciding with or following completion of one month of employment.
- If you are an eligible employee paid on a semi-monthly basis, you are eligible for this Plan on the first day or the fifteenth day of the month coinciding with or following completion of one month of employment.

Contact your agency group representative for further details.

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

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

CHANGING YOUR 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 3rd party Administers. 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 State of New Mexico:

- 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**;
- Marriage of a Dependent child;
- Qualification or disqualification of a domestic partner; and
- Change in employment status (regular part-time to regular full-time or vice versa).

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

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 HMO 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, Co-insurance, 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.

SECTION 4 – COVERED SERVICES

Benefits are subject to the Copayments and Co-insurance listed in the *Summary of Benefits*. Please refer to Section 5 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 "Grievance Procedure" in Section 7.

ACCIDENTAL INJURY/MEDICAL EMERGENCY CARE/URGENT CARE

Medical Emergency Care

Treatment for a Medical Emergency or Accidental Injury in the emergency room of a Hospital or an Urgent Care facility is a benefit and does not require notification to PHP after the event. Please refer to the *Summary of Benefits* for emergency room or Urgent Care facility co-payments. Treatment in a Physician's office or Ambulatory Surgical Facility is also a benefit and is paid as any other illness.

Emergency Care means healthcare procedures, treatments, or services delivered to a covered person 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 layperson, to result in (a) serious dysfunction of any bodily organ or part; or (b) disfigurement to the person.

You may receive your emergency care services from your In-network PCP at his/her direction. When your In-network PCP is not available to personally handle your care, he/she will arrange for another In-network Physician to be available. In-network PCPs have a 24-hour telephone number for this purpose.

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

If your emergency treatment requires direct Admission to the Hospital, you are responsible for the Hospital co-payment, but you do not have to pay a separate Copayment for the emergency room visit. No notification or Prior Authorization is required for Non-In-network (including out of state) Hospitals or treatment facilities for Medical Emergency services.

Coverage for trauma services and all other emergency services will continue at least until the Member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgement of the Attending Physician in consultation with PHP. PHP may require that the Member be transferred to an In-network Hospital or a National PPO Network Hospital, if the patient is stabilized and the transfer completed in accordance with federal law.

Services received from an Out-of-network Provider other than in a Student Health Center, and/or not specifically for the diagnosis and treatment of a Medical Emergency or Urgent Medical needs are not covered under this Plan.

Urgent Care

Urgent Care means Medically Necessary Health Care Services provided in non-life threatening situations, or after a Primary Care Physician's normal business hours for unforeseen conditions due to illness or injury that are not life threatening, but require prompt medical attention.

These are situations that are not life threatening but require prompt medical attention or Urgent Care. Examples of Urgent Care situations include but are not limited to: sprains, high fever, minor cuts, minor burns, requiring stitches, significant vomiting or diarrhea, severe stomach pain, swollen glands, rashes, poisoning, strains, cramps, bumps, bruises and back pain.

You will be reimbursed for all services rendered that satisfy this definition, unless otherwise limited or excluded, if provided by a licensed Provider and/or an appropriate facility for treating urgent medical conditions. Members are encouraged to contact their In-network PCPs for an appointment, if available, before seeking care from another In-network Provider. Members may contact the Presbyterian Customer Service Center for information regarding the closest In-network facility that can provide Urgent Care.

The amount of the Copayment for Emergency and Urgent Care is determined by the location where care is received (i.e. Hospital, Emergency Room, Urgent Care facility, Physician's office).

For Urgent Care received from an Out-of-network Provider, no notification is required. You will be responsible for charges **not covered** by the Plan.

ACUPUNCTURE SERVICES

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

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

AMBULANCE SERVICES

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

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

A tertiary care facility is a Hospital unit that provides:

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

The ambulance Copayment is waived if transportation is Medically Necessary and between medical facilities or results in a Hospital Admission.

There are no benefits when the ambulance transportation is primarily for the convenience of the patient, the patient's family, or the healthcare Provider.

BIOFEEDBACK

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

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

CHIROPRACTIC SERVICES

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

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

CANCER CLINICAL TRIALS

If you are a participant in an approved cancer clinical trial that is being conducted in New Mexico, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention and be designed to study the reoccurrence, early detection, or treatment of cancer. The persons conducting the trial must provide PHP with notice of when the Member enters and leaves a qualified clinical trial.

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include Food and Drug Administration (FDA) approved Prescription Drugs that are not paid for by the manufacturer,

distributor, or Provider of the drug. Member cost-sharing provisions will apply to these benefits. (See your prescription drug booklet for more details)

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

DENTAL CARE AND MEDICAL CONDITIONS OF THE MOUTH AND JAW

Dental Accidents

Treatment for conditions that are the direct result of Accidental Injury to the jaw, sound natural teeth, mouth or face is a benefit. Injury as a result of chewing, biting, or malocclusion is **not** considered an Accidental Injury.

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

All covered treatments for dental trauma must be completed within two years of the specific traumatic injury.

If craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders are a result of trauma such as a bodily injury or blow caused solely through external, violent, and unforeseen means, benefits are available for diagnostic examination, x-rays, medications, physical therapy, dental splints, Acupuncture, orthodontic appliances and treatment, crowns, bridges, and dentures. Trauma does not include injury as a result of biting, chewing, or malocclusion.

When alternative dental or surgical procedures or prosthetic devices are available, the dental accident benefit allowance is based upon the least costly procedure or prosthetic device.

Hospitalization for Dental Care

Hospitalization, day surgery, outpatient services and/or anesthesia for Non-Covered dental services, are Covered if, provided in a hospital or ambulatory surgical center for dental surgery when approved by PHP. 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 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; and
- For *other procedures* for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

Oral Surgery and TMJ Treatment

Oral dental Surgery benefits are available for cutting procedures for diseases, such as:

- Removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required;
- External or intraoral cutting and draining of cellulitis (inflammation) that extends beyond the dental space;
- Surgical correction of prognathism with handicapping malocclusion, a marked projection of the lower jaw that interferes with chewing;
- Removal of bony growths on the jaws and hard palate, unless done in preparation of the mouth for dentures;
- Incision of accessory sinuses, salivary glands, or ducts;
- Reduction of dislocations such as TMJ Surgery; and
- Frenectomy.

Oral Surgery procedures that are covered by your dental carrier's coverage are provided only if a covered benefit under this Plan. Benefits are payable based upon the Coordination of Benefits (COB) requirements set forth in Section 7 of this booklet.

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

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

DIABETES EDUCATION

Diabetes education is a covered benefit that includes coverage for any Provider rendering education or instructional services for diabetes. The Copayment applies to the professional Provider's services **only.**

- Type I Diabetes - For all Members, up to six visits to normalize glucose within two months of diagnosis; thereafter, up to one visit per month as needed to maintain control of diabetes, and if over 18 years of age, there is a four visit per year limit for maintaining control.
- Type II Diabetes - Up to four visits for initial education, plus if insulin is initiated, up to three visits for insulin start up and management; thereafter, up to four follow up visits per Calendar Year.

- Diabetes Occurring Only During Pregnancy ("Gestational Diabetes") - One initial visit; thereafter, two follow up visits per month. In addition, one visit within six months following delivery for conception counseling for patients planning additional children.
- Hypoglycemia and glucose intolerance - Up to three visits to provide necessary nutritional counseling to delay or prevent onset of diabetes.
- Insulin Pump Training - One initial session and one follow up session.
- Additional visits - include following a Physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; or visits when re-education or refresher training is prescribed by a healthcare Provider with prescribing authority.

DIABETES SUPPLIES AND SERVICES

When prescribed by an In-network or an out-of-state National PPO Network Provider (also contact Express Scripts at 1-800-743-1720 about your prescription drug benefits) the following equipment, supplies, appliances, and services are available from a Durable Medical Equipment supplier and are covered for Members with diabetes:

- Standard blood glucose monitors and, specialized blood glucose monitors, when Medically Necessary;
- Test strips for blood glucose monitors;
- Visual reading urine and ketone strips;
- Lancets and lancet devices;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Syringes;
- Medically Necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment when Prior Authorization is obtained from PHP;
- Glucagon emergency kits; and
- Insulin pumps when Medically Necessary and prescribed by an In-network endocrinologist.

If you obtain services from an In-network Provider, they will request Prior Authorizations from PHP, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, you will be responsible for a $250 penalty for covered facility services (in addition to Copayments, Deductibles, and/or Co-insurance as listed in the *Summary of Benefits*) or benefits may be denied. Discuss the need for Prior Authorizations with your Physician before obtaining services.

Diabetic Supplies and Equipment – Pregnancy Related

The following supplies are covered for diabetic Members and individuals with elevated blood glucose levels due to pregnancy, not to exceed a one-month supply purchased during any 34-day period:

- autolet, lancets, and lancet devices;
- insulin pump supplies;

- blood glucose and visual reading urine and ketone test strips;
- injection aids, including those adaptable to meet the needs of the legally blind; and
- syringes and needles.

The following equipment is also covered for diabetic Members and individuals with elevated blood glucose levels due to pregnancy:

- insulin pumps;
- glucagon emergency kits;
- blood glucose monitors, including those for the legally blind; and
- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications when Prior Authorization is obtained from PHP.

DIAGNOSTIC SERVICES

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

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;
- Genetic testing unless it is determined to be Investigational;
- Chromosome analysis, including karyotyping and molecular cytogenetic testing;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Hearing tests **only** for the treatment of an illness or Accidental Injury;
- Magnetic Resonance Imaging (MRI) - (require Prior Authorization);
- Positron Emissions Tomography (PET) scans - (require Prior Authorization);
- Sleep disorders - sleep lab studies can be performed in a certified sleep lab or as part of a home sleep study approved by the PHP; and
- Allergy testing.

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

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

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

- The rental or, at the option of PHP, the purchase of Durable Medical Equipment when prescribed by a Physician or other professional Provider and required for therapeutic use, including Wheelchairs, Hospital beds, crutches, and other necessary Durable Medical Equipment;

- Purchase, fitting and necessary adjustments of prosthetic devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity;
- Prosthetic eyes and prosthodontic appliances;
- Breast prosthetics when required as the result of a mastectomy;
- Orthotic (a rigid or semi-rigid supportive device) or Orthopedic Appliance (Prefabricated) that supports or eliminates motion of a weak or diseased body part. This does not include foot orthotics, functional or otherwise;
- Custom-Fabricated knee-ankle-foot Orthoses (AFO and/or KAFO) in accordance with existing Medicare guidelines;
- Contact lenses for aphakia (those with no lens in the eye) or keratoconus;
- Sclera shells (white supporting tissue of eyeball);
- Initially, either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intra-ocular Surgery or ocular injury, or prescribed by a Physician as the only treatment available for keratoconus. The following guidelines apply to eyeglasses provided under this benefit:
  - Only standard frames are covered. Deluxe frames are not covered.
  - Ultraviolet (UV) protection is covered.
  - Anti-reflective coating, tints, or oversize lenses are covered only when they are Medically Necessary for the individual patient and Medical Necessity is documented by your treating Physician.
  - Bifocal lenses in frames or lenses in frames for far vision and lenses in frames for near vision are covered only when determined to be Reasonable and Customary.
  - Tinted lenses, including photochromatic lenses, used as sunglasses, which are prescribed in addition to regular prosthetic lenses, are not covered.
  - Scratch resistant coating, mirror coating, polarization and progressive lenses are not covered.
  - Lenses made of polycarbonate or other impact-resistant materials are covered for a patient with functional vision in only one eye.
  - Use of polycarbonate or similar material or high index glass or plastic for indications such as light weight or thinness is considered deluxe, and therefore, is not covered.
  - Eye glass cases are not covered.
  - Duplicates are **not covered** and replacement is covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.
- Hearing aids, to include repair and replacement, and associated testing. Associated office visits for hearing evaluations are subject to the appropriate Copayment or Co-insurance;
- Stethoscopes and manual blood pressure cuffs that are prescribed by a Physician. Automatic blood pressure cuffs or monitors are **not covered** unless the Member is physically unable to use a manual cuff; and
- Repairs or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the Member's condition, or after the product's normal life expectancy has been reached and when Prior Authorization is obtained from PHP.

Surgically implantable devices and prostheses are covered as follows:

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

When alternative prosthetic/orthotic devices are available, the allowance for a prosthesis/orthosis will be based upon the least costly item.

Medical Supplies

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

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

Prior Authorization from PHP is required for the following:

- Durable Medical Equipment, medical supplies (including enteral feeding tubes), orthopedics appliances, orthotics, and surgically implanted prosthetics; and
- Any item costing $1,000 or more in total charges dispensed in the Physician's office. (Total charges means either the total purchase price of the item or total rental charges for the estimated period of use. Rental charges considered for benefit payment will not exceed the purchase price of a new Unit.)

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

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

- Deluxe equipment such as motor-driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate;
- Rental of Durable Medical Equipment if the patient is in a facility that provides such equipment;

- Cost of repairs that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;
- Dental appliances including dentures;
- Equipment that is primarily non-medical such as heating pads, hot water bottles, water beds, Jacuzzi units, specialized clothing, hot tubs, or exercise equipment;
- Environmental control equipment such as air conditioners, dehumidifiers, or electronic air filters, regardless of the therapeutic value they may provide;
- Accommodative foot orthotics, which are used to accommodate the structural abnormalities of the foot by providing comfort, but not altering function;
- Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by PHP), except for Members with diabetes or other significant neuropathies when Prior Authorized by PHP;
- Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints, except for Members with diabetes or other significant neuropathies when Prior Authorization is obtained from PHP;
- Duplicate equipment is **not covered** under this Plan.

FAMILY, INFANT AND TODDLER (FIT) PROGRAM

Coverage for children, from birth to age three, for or under the Family, Infant and Toddler Program (FIT) administered by the Department of Health, provided eligibility criteria are met, is provided for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & children Health Care Services. Benefits used under this section will not be applied to any maximum lifetime or annual plan limits applicable to this plan. This benefit is subject to an annual maximum.

FAMILY PLANNING AND RELATED SERVICES

Family planning services, when provided by an In-network or National PPO Network Provider are covered for the following procedures:

- Injection of Depo-Provera for birth control purposes;
- Diaphragm, including fitting;
- Implantable contraceptive devices, including surgical implantation and removal;
- Intrauterine Devices (IUDs) or cervical caps, including fitting, insertion, and removal;
- Genetic counseling;
- Surgical sterilization procedures such as vasectomies and tubal ligations (if the tubal ligation is done during a delivery, only the Maternity Copayment applies. there will not be an additional Surgery Copayment);
- Elective and therapeutic abortions; and
- RU486 (Mifeprex®) administered by a Physician.

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

GENETIC INBORN ERRORS OF METABOLISM DISORDERS (IEM)

Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the Limitations and Exclusions, (Section 5) and Prior Authorization (Section 2) requirements listed in the Summary Plan Description. Medical services provided by licensed Health Care Professionals, including Physicians, dieticians and nutritionists, with specific training in managing Members diagnosed with Genetic Inborn Errors of Metabolism (IEM) are Covered. Covered Services include:

- nutritional and medical assessment;
- clinical services;
- biochemical analysis;
- medical supplies;
- Prescription Drugs;
- corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM);
- nutritional management;
- elective and therapeutic abortions; and
- Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status when Prior Authorization is obtained from PHP's pharmacy department.

For prescription drug and special medical foods coverage, contact Express Scripts.

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

HABILITATIVE

Autism Spectrum Disorder

The diagnosis and treatment for Autism Spectrum Disorder is covered for children, from birth to age nineteen (19) or up to age twenty-two (22) if enrolled in high school, in accordance with state mandated benefits as follows:

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

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

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

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

HOME HEALTH CARE

If a Member needs health care at home, benefits are available for services provided by a Home Health Agency. This benefit provides skilled nursing services when ordered by a Physician and administered in the home on an intermittent basis. A visit is one period of home health service of up to four hours.

Before the Member receives home health care, the treating Physician, Home Health Agency, or Member must request Prior Authorization from PHP. If you obtain services from an In-network Provider, they will request Prior Authorizations from PHP. If you obtain services from an out-of-state National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to obtain Prior Authorization before obtaining services may result in a $250 penalty for covered services (in addition to Copayments, Deductibles, and/or Co-insurance as listed in the *Summary of Benefits*) or your benefits may be denied. Discuss the need for Prior Authorizations with your Physician before obtaining services.
The following home health care services are covered:

- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);

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

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

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

HOSPICE CARE

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

Before the Member receives Hospice care, the treating Physician or Hospice agency must request Prior Authorization from PHP. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-state National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. If you fail to obtain Prior Authorization, you will be responsible for a $250 penalty for covered facility services (in addition to Copayments, Deductibles, and/or Co-insurance as listed in the *Summary of Benefits*) or your benefits may be denied. Discuss the need for Prior Authorizations with your Physician before obtaining services.

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

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

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

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

The following services are covered under this Hospice benefit:
- Inpatient Hospice care;
- Hospice care Physician benefits;
- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- Home health care by a home health aide;
- Physical therapy, speech therapy, or occupational therapy;
- Medical supplies; and
- Drugs and medications for the terminally ill patient.

In addition to the Hospice services listed above, and limits as specified on the *Summary of Benefits*, you have coverage for the following:
- Services of a medical social worker (MA or MSW) for patient or family counseling, to include bereavement counseling limited to three visits; and
- Respite care for a period not to exceed ten continuous days. - No more than two respite care stays are available during a six-month Hospice benefit period. Respite care provides a brief break from total care given by the family.

Hospice benefits are **not** available for the following services:
- Food, housing, or delivered meals;
- Medical transportation;
- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing; and
- Pastoral and spiritual counseling.

The following services are **not** benefits under Hospice but may be covered elsewhere under this booklet, subject to applicable Copayment and Co-insurance provisions:
- Acute Inpatient Hospital care for curative services;
- Durable Medical Equipment;
- Non-Hospice care Physician visits; and
- Ambulance Services.

HOSPITAL INPATIENT SERVICES

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

Benefits are available for a non-private room with two or more beds. Private room charges are a covered benefit only when Medically Necessary and when the private room is ordered by an In-network Provider or the admitting Physician and Prior Authorization is obtained from PHP. If the Member requests a private room or the private room is not Medically Necessary, PHP bases

payment on the Hospital's average non-private room rate and the Member is responsible for the balance. The balance you pay does not apply to the Out-of-pocket Maximum.

Benefits are available for other room accommodations or special care units such as:
- Intensive Care Unit (ICU);
- Cardiac Care Unit (CCU);
- Sub-Intensive Care Unit; and
- Isolation Room.

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

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

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

There are **no** benefits for Maintenance Therapy or care provided after the patient has reached his/her rehabilitative potential. In the case of a dispute about whether the patient's rehabilitative potential has been reached, the patient is responsible for furnishing documentation from the treating Physician supporting that the patient's rehabilitative potential has not been reached.
If you are re-admitted (inpatient) to the same hospital or inpatient medical facility within 15 days of being discharged and the diagnosis is the same or similar, this may be considered one inpatient stay and you may be responsible for only one inpatient Copayment. If this situation occurs, please contact Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at (505) 923-5600, or toll free at 1-888-275-7737, after you have been discharged the second time.

Benefits are subject to a Calendar Year limit as shown in the *Summary of Benefits* in combination with benefits for Acupuncture and chiropractic services.

MATERNITY AND NEWBORN CARE

Benefits include complete prenatal care, pregnancy related diagnostic tests, Prescription Drugs, visits to an obstetrician, Nurse-Midwife, or licensed midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse Midwife or Physician. Lay midwife deliveries are not a covered benefit. Deliveries by cesarean section, ectopic pregnancies, other

pregnancy complications, such as miscarriage, and therapeutic or elective abortions are also covered.

If Maternity benefits change during a pregnancy, the Member receives the benefits in effect on the day the service is received.

Under Two-Party or Family Coverage, a Dependent daughter is eligible for Maternity benefits. Coverage for the baby is available **only** if covered as an eligible Dependent.

Note:
To add coverage for your newborn child, you must submit an Application for your child as a Dependent before or within 31 days of birth. If enrolled within 31 days of birth, the baby is then covered from the moment of birth. If you have Employee coverage, you must change to Two-Party coverage; if you have Two-Party coverage, you must change to Family Coverage; if you already have Family Coverage; you must submit an Application to add your newborn as a Dependent and select a PCP to coordinate your newborn's care.

If the baby is enrolled within 31 days, newborn visits in the Hospital by the baby's Physician, circumcision, incubator, and routine Hospital nursery charges are covered. If your baby needs special care including diagnostic tests and Surgery, the Plan pays benefits for that care too.

A separate Deductible and Inpatient Copayment for your newborn applies only when the infant's inpatient stay exceeds the mother's date of discharge. Additional services above and beyond routine newborn care are not subject to an additional Copayment if the infant is discharged on the same day or before the mother is discharged from the Hospital.
If your newborn stays in the Hospital longer than the mother does, you must notify PHP Health Services by calling toll-free 1-888-275-7737, before the mother's discharge from the Hospital, to coordinate the baby's care.

If a newborn is re-admitted (inpatient) to the same hospital or inpatient medical facility within 15 days of being discharged and the diagnosis is the same or similar, this may be considered one inpatient stay and you may be responsible for only one inpatient Copayment. If this situation occurs, please contact the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at (505) 923-5600, or toll free at 1-888-275-7737, after you have been discharged the second time.

Newborns and Mothers Health Protection Act

Federal law prohibits us from restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. You need not obtain Prior Authorization from PHP for a length of stay not in excess of the above periods.

MENTAL HEALTH AND ALCOHOLISM AND/OR SUBSTANCE ABUSE

To obtain benefits for services related to Mental Health and Alcoholism and/or Substance Abuse Members need only call PHP Behavioral Health directly at 1-800-453-4347 and ask for the Behavioral Health Department.

All Admissions or partial hospitalization for Mental Health or Alcoholism and/or Substance Abuse require Prior Authorization by the PHP Behavioral Health Department, with the exception of life-threatening emergencies. Services may not be covered or you may incur a $250 penalty (in addition to Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) if Prior Authorization is not obtained prior to services being rendered.

The following benefits are applicable for Mental Health and Alcoholism and/or Substance Abuse Services. In all cases, Mental Health treatment and Alcoholism and/or Substance Abuse treatment must be Medically Necessary in order to be covered.

Copayments for Facility-Based Intensive Outpatient Programs (IOP) are listed below. Non-facility based programs will apply regular Copayments on a per-visit basis.

- Partial hospitalization with step down from Inpatient – No Copayment
- Intensive Outpatient with step down from Inpatient or Partial hospitalization – No Copayment

Outpatient services are available from the following credentialed Providers:

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

Mental Health Services

Inpatient Mental Health services will be covered in an In-network or National PPO Network facility when performed by a licensed In-network or National PPO Network Provider. Inpatient care requires Prior Authorization from PHP's Behavioral Health Department. Please call 1-800-453-4347 and press the * key to access the Behavior Health Department.

Partial hospitalization can be substituted for the Inpatient Mental Health services. Partial hospitalization is a non-residential Hospital-based day program attended by the Member at least 3 hours a day but not more than 12 hours in any 24-hour period that includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Services require Prior Authorization by PHP's Behavioral Health Department. If you fail to obtain Prior Authorization when required, you will be responsible for a $250 penalty for covered facility services (in addition to Copayments, Deductibles, and/or Co-insurance as listed in the *Summary of Benefits*) or benefits may be denied. Outpatient, non-Hospital based, short-term evaluative and therapeutic Mental Health services will be provided based on Medical Necessity.

Coverage includes services for diagnostic tests, anesthetics, x-ray and laboratory examinations, and other care provided by a professional Provider, Hospital or Admission treatment center.
Outpatient services also include treatment, to include individual, group or family counseling, medication management and neuropsychological testing for Mental Health and/or Substance Abuse for most Mental Health diagnoses. In addition, therapies for marriage, family and relationship problems, physical and/or sexual abuse, and problems related to a Mental Disorder or medical condition are also covered.

Alcoholism and Substance Abuse Dependence Services
Coverage is provided for a combination of Acute Inpatient Hospital services and partial hospitalization services for Alcoholism and Substance Abuse Dependence. Acute Inpatient Hospital services, partial hospitalization and services at a Residential Treatment Center require Prior Authorization from PHP's Behavioral Health Department. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-network National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

Coverage for Alcoholism and Substance Abuse Dependence services at a Residential Treatment Center (RTC) is limited to 60 days per member per Calendar Year. Coverage for RTC services is limited to two courses of treatment (regardless of the number of days) per member per lifetime. A course of treatment is a planned, structured, and organized program to promote an alcohol and/or Substance Abuse free status that may include different facilities or modalities including Acute Inpatient Hospital, partial hospitalization, RTC services and outpatient services.
The following limitations apply to a course of treatment:

Acute Inpatient Hospital services in a Hospital or Substance Abuse Dependence treatment center requires Prior Authorization from PHP's Behavioral Health Department prior to Admission. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-network National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

- Partial hospitalization is a non-residential day program, attended by the Member at least eight hours a day, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Acute Inpatient Hospital services care. Partial hospitalization services require Prior Authorization from PHP's Behavioral Health Department. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied. Outpatient, non-Hospital based, evaluative and therapeutic Alcoholism and Substance Abuse Dependence services are covered as individual, family, or group counseling. Outpatient visits are defined as visits lasting up to 50 minutes.

- Intensive Outpatient Alcohol and Substance Abuse Dependence services are covered as individual, family, or group counseling. Intensive Outpatient Alcohol and Substance Abuse Dependence services are defined as a structured program of visits lasting three hours per visit and attended by the Member three times per week.
- A course of treatment will be considered complete if any one of the following occurs:
  - the Member is discharged on medical advice from Acute Inpatient Hospital services treatment, partial hospitalization, RTC services and/or intensive outpatient services;
  - immunization Member has reached the annual maximum benefit for Alcoholism and Substance Abuse Dependence services; or
  - the Member fails to materially comply with any treatment program for a period of 30 days

NAPRAPATHIC SERVICES

Any covered service of a Licensed Naprapathic, including hand manipulation of connective tissue, intended to release tension and restore structural balance. Benefits are subject to a Calendar Year limit as shown in the *Summary of Benefits*.

PHYSICIAN SERVICES

Please refer to the *Summary of Benefits* for applicable Copayments for the following services:

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

Contraceptive Devices
Benefits are available for contraceptive devices that require a prescription by a Physician including:
- IUDs;
- Diaphragms; and
- Other implantable contraceptive devices.

If you must obtain the IUD, diaphragm, or other implantable contraceptive device from a pharmacy, you will have to pay for the item and then file a claim with the PHP. All other contraceptive devices that do not require a prescription are not a benefit. For oral contraceptive prescription drug benefits, see the Express Scripts benefits booklet.

Injectable Drugs
FDA-approved therapeutic injections administered in a Provider's office are covered. However, certain injectable drugs (such as growth hormone and interferon alfa-2) are covered only when Prior Authorization is received from PHP. Your PHP In-network Provider has a list of those injectable drugs that require Prior Authorization. If you need a copy of the list, contact a

Presbyterian Customer Service Center representative. For allergy injections, please refer to the *Summary of Benefits*.

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

Inpatient Physician Visits and Consultations
Attending Physician visits and consultations in the Hospital are benefits during a covered Admission.

Obstetrics/Gynecological Visits
Women can obtain gynecological care for routine exams and other obstetrical and/or gynecological care from In-network OB/GYN providers.

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

Weight Management and Nutritional Counseling
Weight loss management, obesity treatment, and nutritional counseling are not a benefit unless dietary advice and exercise are provided by a Physician, licensed nutritionist, or registered dietician. Weight loss management, obesity treatment, and nutritional counseling must be prescribed by a PCP or In-network Provider and are a benefit only when Medically Necessary and for a body mass index (BMI - weight in kilograms divided by height in meters squared) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions. Member must have demonstrated adherence with all prescribed medications and treatment instructions. Appropriate documentation is required. Specific obesity-related co-morbidities include, but are not limited to:

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

Weight loss medications require **Pre-Approval** by Express Scripts, your prescription drug plan for State of New Mexico employees. Express Scripts can be reached at 1-800-743-1720. Also see Morbid Obesity under *Surgery* section.

Note:

If you disagree with PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See "Grievance Procedure" in Section 7.

PREVENTIVE SERVICES

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

Benefit payments for services listed in this section are not subject to Copayments.

The services listed below, including the diagnosis of osteoporosis, are covered.

Cytologic Screening (Pap smear screening)
Benefits are available to determine the presence of pre-cancerous or cancerous conditions and other health problems in accordance with the national medical standards for women and for women who are at risk of cancer or at risk of other health conditions that can be identified through a cytology screening.

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

Health Education and Counseling
Health education and counseling services will be provided if recommended by your treating Physician and if consistent with PHP policy, including:

- If you are 21 years of age or older, you may receive an annual consultation to discuss lifestyle behaviors that promote health and well being. Included in the consultation may be, but not limited to:
  - smoking control;
  - nutrition and diet recommendations;
  - exercise plans;
  - immunization practices;
  - use of seat-belts in motor vehicles; and
  - other preventive healthcare practices.
- If you are under age 21, educational materials or consultation to discuss lifestyle behaviors that promote health and wellbeing including, but not limited to:
  - the consequences of tobacco and vaping use;
  - nutrition and diet recommendations;
  - exercise plans; and
  - as deemed appropriate by the treating Physician or as requested by the parents or legal guardian for children under 18, educational information on alcohol and Substance Abuse, sexually transmitted diseases and contraception.

Mammography Coverage
Benefits are available for mammograms for determining the presence of breast cancer. Guidelines for a routine mammography are:
- A baseline at age 40;
- One every 1-2 years for ages 40 and over; and
- As otherwise medically indicated.

Routine Eye Screening

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A comprehensive eye examination should be performed as soon as possible to determine whether a vision problem is the root cause of any developmental delay.

Routine Hearing Screening
Hearing should be screened whenever parents express concern about hearing or language development.

Routine Immunizations
For additional immunization coverage, please contact Express Scripts at 1-800-743-1720 to see what is covered under their preventive program.
Ask your PCP or nurse at every office visit if you or your child needs immunizations. You can also check recommendations by the Advisory Committee on immunizations. Practices (ACIP) at https://www.cdc.gov/vaccines/index.html.

Routine Physical Examinations
This benefit provides routine physical, breast, gynecological and pelvic examinations and is not subject to an office visit Copayment. In addition, periodic tests to determine blood hemoglobin, blood pressure and blood glucose level are also covered.

Additional preventative services as recommended by the U.S. Preventive Services Task Force:
- Periodic blood cholesterol, or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level;
- Periodic stool examination for the presence of blood for Members age 50-75;

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

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

Well-Child Care
Coverage is provided in accordance with the schedule of well-child exams suggested by the American Academy of Pediatrics as follows:

- During 1st year of age at 1, 2, 4, 6, 9, and 12 months;
- During 2nd year of age at 15, 18, and 24 months;
- Yearly check-ups for ages 3 and 4; and
- Every year for ages 3 through 18.

Preventive Services for women

- Well-woman visits to include adult and female-specific screenings and preventive benefits
  - Counseling for HIV, sexually transmitted diseases and domestic violence and abuse.
  - Domestic and interpersonal violence screening and counseling for all women.
  - Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
    - Generic birth control (See Pharmacy benefits);
    - Intrauterine devices (IUD);
    - Hormone contraceptive injections;
    - Inserted contraceptive devices; and
    - Implanted contraceptive devices.
  - Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
  - Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
  - Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
  - Screenings and counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast feeding counseling.
  - Sexually Transmitted Infections (STI) counseling for sexually active women.
  - Well-woman visits to obtain recommended preventive services.

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

SKILLED NURSING FACILITY

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

A skilled nursing facility is not an institution, or part of one, used mainly for rest care, care of the aged, care of Substance Abuse treatment, Custodial Care, or educational care.

Note:

Prior Authorization is required for Skilled Nursing Facility benefits. The Inpatient Copayment is waived if confinement in the Skilled Nursing Facility is within 15 days after release from the Hospital and the stay is subject to continued stay review for Medical Necessity. If you obtain services from an In-network Provider, they will request Prior Authorizations from PHP. If you obtain services from an out-of-state National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied. Discuss the need for Prior Authorizations with your Physician before obtaining services.

SMOKING CESSATION

Benefits are available for smoking cessation expenses up to a maximum benefit per Member per lifetime as shown in the *Summary of Benefits*. This benefit includes Acupuncture, hypnotherapy and other recognized smoking cessation programs that are covered through the medical portion of the Plan. In addition, benefits can be accessed through Express Scripts, your prescription drug Provider to include Nicorette or any other drug containing nicotine or other smoking deterrent medications.

In order to use this benefit, Members must secure medical services and/or purchase the smoking deterrent and pay for the services and drugs in full. All claims for medical services must then be filed through the medical portion of the Plan using a Member Claim Form. All prescription and non-prescription drug claims must be sent as separate claims to Express Scripts, your prescription drug Plan.

SURGERY

Benefits are available for the following surgical services:

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

Cosmetic or plastic Surgery or reconstruction procedures, such as breast augmentations, rhinoplasties, surgical alteration of the eye, and surgical correction of prognathism, that PHP determines are not required to materially improve the physiological function of an organ or body part are **not** Covered Services. Services for the reconstruction of surgically induced scars are not benefits under any circumstances. Also, additional Surgery or treatment required to care for or to correct a complication due to a previous Surgery is **not** a benefit.

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

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

Contact lenses are also available when necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or ocular injury, or prescribed by a Physician as the only treatment available for keratoconus. Services must be Medically Necessary and further replacement is covered only if a Physician or optometrist recommends a change in prescription.

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

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

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

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

- Is a Covered Benefit only if a Member meets this criteria and all other requirements of this Agreement.

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

- Cardiomyophathy.
- Congestive heart failure with an ejection fraction of 50% or less than predicted.
- Documentation of previous myocardial infarction requiring hospitalization.
- Documented Type 2 diabetes mellitus.
- Uncontrolled/massive leg lymphedema.
- Obstructive sleep apnea with baseline AHI or RDI of 15 or greater, or currently under treatment with a positive pressure device (CPAP, BiPAP, C-Flex, etc.).

- Obesity related osteoarthritis of the lower extremities for which joint replacement surgery of the knee or ankle has been recommended.
- Pickwickian syndrome or cor pulmonale.

Prior Authorization may be required. Also see Weight Management.

Oral Surgery
See "Dental Care and Medical Condition of the Mouth and Jaw" in this Section.

Outpatient Surgery
Benefits are available for Medically Necessary surgical procedures performed in an Outpatient setting (there is no Hospital Admission). Some services require Prior Authorization before the outpatient surgery is covered. The Member or Provider must obtain Prior Authorization from PHP before the service is provided.

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

Reconstructive Surgery that is required as a consequence of an Accidental Injury or breast reconstruction subsequent to a mastectomy (breast removal) required as a consequence of disease, is a benefit. The Member or Provider must obtain Prior Authorization from PHP before the service is provided. Reconstructive surgeries provided without prior written Prior Authorization are **not** eligible for benefits under this Plan.

Mastectomy Services – Medically Necessary hospitalization related to a covered mastectomy including at least 48 hours of Inpatient care following a mastectomy and 24 hours following a lymph node dissection is covered.

When breast reconstruction is chosen, Covered Services include;
- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas as determined by the Attending Physician and the patient.

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

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

Note:
If you disagree with PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See "Grievance Procedure" in Section 7.

THERAPY

Cardiac and/or Pulmonary Rehabilitation
Benefits are available for Outpatient cardiac and/or pulmonary rehabilitation programs.

Chemotherapy/Dialysis/Radiation Therapy
Benefits are available for the following Inpatient or Outpatient therapeutic services:

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

Physical, Occupational and Speech Therapy
Benefits are available for Outpatient rehabilitation services including physical therapy from a Licensed Physical Therapist, and occupational or speech therapy from a licensed or certified therapist. Benefits are **not** available for speech therapy in connection with learning disabilities.

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

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

Note:
If you disagree with PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See "Grievance Procedure" in Section 7.

TRANSPLANT SERVICES

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

Human transplant benefits are available for cornea, hear, heart/lung, lung, intestinal, kidney, liver, pancreas, and pancreas islet cell infusion. Bone marrow transplants are covered ONLY for leukemia, aplastic anemia, lymphoma, severe combined immunodeficiency (SCID) Wiskott-

Aldrich syndrome, Amyoloidosis, and multiple myeloma. "Bone Marrow Transplant" includes peripheral bone marrow stem cell harvesting and transplantation following high dose chemotherapy.

Prescreening costs at the time of the transplant evaluation and services necessary to complete the evaluation are included in the benefit.
Organ transplant services include the recipient's medical, surgical and Hospital services; Inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the services outlined previously (in paragraph two above.

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

Prior Authorization must be obtained from PHP before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if Prior Authorization is not obtained from PHP. A PHP case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied. Discuss the need for Prior Authorizations with your Physician before obtaining services.

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

In addition, benefits are available **only** when the transplant is performed at a facility with a transplant program approved by PHP. Call PHP toll free at 1-888-275-7737, for a current list of PHP approved programs.

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

Organ Procurement or Donor Expenses: If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver are also covered. If there is a living donor that requires Surgery to make an organ available for a covered transplant (e.g., kidney or liver), coverage is available for expenses incurred by the donor for travel (if required, covered under the "Transplant" provision, and approved by the PHP case manager), Surgery, organ storage expenses, and Inpatient follow-up care only.

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

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

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

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

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

- Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- Lodging while at, or traveling to and from transplant site; and
- Food while at, or traveling to and from the transplant site.

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

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

- Travel costs incurred due to travel within 60 miles of your home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products; and
- Charges for transportation that exceed coach class rates.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Travel benefits are available for an adult transplant recipient and one other person or for a transplant recipient who is a minor; benefits are available for two adults. Transportation costs will be covered only if travel beyond 60 miles of your home is required. Reasonable expenses for lodging and meals will be covered, up to a maximum of $125 per day for each person, the transplant recipient and companion(s). All benefits for transportation, lodging, and meals are limited to a maximum payment of $10,000.

Benefits are **not** available for implantation of artificial organs, mechanical devices or for non-human organ transplants and those services otherwise listed as covered elsewhere in this booklet. Follow-up care and complications of non-covered transplants are **not** a covered benefit.

Benefits are subject to the same Copayment, Co-insurance and Out-of-Pocket Maximum provisions as other benefits. The cost-sharing provisions of the coverage in effect on the date services are rendered apply to the transplant benefits.

Note:
If you disagree with PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See "Grievance Procedure" in Section 7.

SECTION 5 – LIMITATIONS AND EXCLUSIONS

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

Note:
If you disagree with PHP's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the PHP decision at any time. See "Grievance Procedure" in Section 7.

LIMITATIONS

The following benefits have limits applied:

Acupuncture treatment benefits are limited to a Calendar Year maximum of $1,500 per Member for covered expenses, in combination with services provided for chiropractic.

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

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

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

Chiropractic (manipulation) services are limited to a Calendar Year maximum benefit of $1,500 per Member for covered expenses, in combination with services provided for Acupuncture.

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

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

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

SECTION 5 – LIMITATIONS AND EXCLUSIONS

This Plan covers only those procedures listed as covered benefits. This Plan does not cover any other oral or dental procedures such as, but not limited to:

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

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

Durable Medical Equipment, orthotic and prosthetic devices and external prostheses require **Prior Authorization** when costs exceed $1,000. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

Family planning coverage is limited to Depo-Provera injections, diaphragms, implantable contraception devices (insertion and removal), intrauterine devices (IUDs), genetic testing, and sterilization procedures. Therapeutic or elective abortions are also covered.

Home health care services require Prior Authorization. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

Hospice care benefits are limited to patients terminally ill as described in Section 4. Prior Authorization is required from the Plan. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-state National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

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

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

Preventive services are limited to services directed by your PCP and suggested frequency schedules in Section 4.

Reconstructive Surgery requires Prior Authorization. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-network National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

Repair or replacement of non-rental Durable Medical Equipment, orthotic appliances and prosthetic devices due to normal wear and damage requires Prior Authorization. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-network National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

Respite care for a Hospice caretaker will be limited to two respite stays of 10 days per benefit period**.**

Routine eye screenings are limited to Dependents through age 17.

Routine hearing screenings are limited to Dependents through age 26.

Routine physical exams and other preventive care services are limited to schedules as detailed in Section 4.

Skilled Nursing Care is subject to Prior Authorization by PHP. If you obtain services from an In-network Provider, they will request Prior Authorization from PHP. If you obtain services from an out-of-network National PPO Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to do so will result in a penalty of $250 (in addition to any Copayment, Deductible and/or Co-insurance amounts listed on the *Summary of Benefits*) or benefits being denied.

Alcohol and/or Substance Abuse Dependence Abuse benefits are limited as follows: Services at a Residential Treatment Center (RTC) are limited to 60 days per Calendar Year. Coverage for RTC is limited to two courses of treatment (regardless of the number of days) per member per

lifetime. All Alcohol and Substance Abuse Dependence services may require Prior Authorization to be considered an eligible expense under this Plan.

Transplants - Benefits for travel, lodging, and meals are limited to the adult transplant recipient and one other person. For minor children, benefits are payable for two other persons. Lodging and meals are limited to $125 per day per person including the transplant patient, to a maximum lifetime benefit payment of $10,000, to include transportation. Donor organ procurement costs for the surgical removal, storage, and transportation of the donated organ are covered for Reasonable and Customary Charge.

Weight loss treatment for obesity is subject to Medical Necessity**.**

EXCLUSIONS

Any service, supply, item or treatment not listed as a covered service in Sections 4. "Covered Services" is **not covered** under this Plan. Benefits are not available for any of the following services, supplies, items, situations, or related expenses:

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

Adoption/Surrogate expenses are not a covered benefit.

Ambulance (including air ambulance) charges which are not medically necessary.

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

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

Autopsies are not a covered benefit under this Plan.

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

Behavioral disorders are not a covered benefit under this unless associated with a manifested Mental Disorder.

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

Charges

- In excess of Plan limits.
- In excess of Reasonable and Customary amounts when services are secured from an Out-of-network Provider in an emergency or urgent need or for transplant services.
- Made by a family Member (spouse, parent, grandparent, sibling or child) or someone who lives with you.

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

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

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

Convalescent care or rest cures.

Cosmetic and/or plastic Surgery or services, unless specifically covered in this booklet. Cosmetic Surgery is beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic. The Plan does not cover Cosmetic Surgery, services or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. This Plan does not cover services related to a cosmetic service, procedure, or Surgery, or required as a result of a non-covered cosmetic service, procedure, or Surgery.

Counseling services are not a covered benefit under this Plan unless listed as a covered service.

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

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

Dental services except as provided in Section 4 *Covered Services,* "Dental Care and medical Conditions of the Mouth and Jaw". Hospitalization, day surgery outpatient services and/or anesthesia for Non-Covered dental services are covered if provided in a hospital or ambulatory surgical center for dental surgery when approved by PHP.

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

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

Diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.

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

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

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

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

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

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

Educational or institutional services except for diabetes education and preventive care provided under routine services as described in Section 4.

Environmental control expenses are not a covered benefit under this Plan.

Exercise equipment is not a covered benefit under this Plan.

Experimental or Investigational services/treatments are **not covered** benefits. Experimental/ Investigational means any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and **not** Experimental or Investigational, treatment must meet all five of the following criteria:
- A technology must have final approval from the appropriate regulatory government bodies;
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the Investigational settings.

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

Food and lodging expenses are **not covered** except for those that are eligible for per diem coverage under the "Transplant Services" provision in Section 4.

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

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

Home births.

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

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

Additionally, the following services are not benefits under Hospice but may be covered elsewhere under this booklet:
- Acute Inpatient Hospital care for curative services;
- Durable Medical Equipment;
- Non-Hospice care Physician visits; and
- Ambulance Services.

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

Hypnotherapy or services related to hypnosis, whether for medical or anesthetic purposes, except as covered under "Smoking Cessation Treatment" provision in Section 4.

Infertility testing and treatment not listed as a covered benefit under this Plan. Also see the exclusion under Artificial Conception.

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

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

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

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

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

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

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

Massage therapy is **not covered** under this Plan.

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

Medically unnecessary services: This plan does not cover services that are not Medically Necessary as defined in the beginning of Section 4, unless such services are specifically listed as covered (e.g., see "Preventive Services" in Section 4).

Membership fees are not a covered benefit under this Plan.

Mental Health and Alcoholism and/or Substance Abuse for the following are **not covered**:

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

Mobile or temporary testing units who submit a bill to this Plan will have those charges denied, to include services for pap smears, mammography, OB/GYN services, adult general screening and physicals.

Non-covered Providers: Members of your immediate family or one normally residing in your home, health spas or health fitness centers, school infirmaries (except for Student Health Centers at institutions of higher education), private sanitariums, nursing homes, rest homes, or dental or medical departments sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.

Non-human organ transplants, except for porcine (pig) heart valve, are **not covered** under this Plan.

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

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

Nonprescription and over the counter drugs as well as:

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

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

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

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

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

Orthopedic shoes are not a covered benefit under this Plan unless the shoes are attached to a brace, or for treatment of diabetes.

Orthoptics are not a covered benefit under this Plan.

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

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

Physical examinations and/or immunizations for purposes of employment, insurance, premarital or international travel tests, sports, school, camp, other non-preventive tests, and those requested by a third party, are **not covered** under this Plan unless considered Medically Necessary by the Plan.

Post-termination care: This Plan does not cover services received after your coverage is terminated, even if Prior Authorization for such services were needed because of an event that occurred while you were covered. Benefits are available for Covered Services related to and received during a covered Hospital Admission that began before coverage ended. Coverage for the Admission and related Inpatient services continues until the earlier of the date: 1) benefits for the Admission are exhausted, or 2) when there is an interruption of the Inpatient stay (such as discharge or a leave of absence from the facility, regardless of the date of discharge).

Prescription drugs obtained on an Outpatient basis are **not covered** under the medical portion of this Plan. If you have questions about your other Outpatient prescription drug benefits contact Express Scripts at 1-800-743-1720.

Private room expenses are not a covered benefit under this Plan unless there is documented Medical Necessity.

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

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

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

Repair or replacement of Durable Medical Equipment, orthotic appliances and prosthetic devices due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience.

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

Rolfing is **not covered** under this Plan

Self-help programs and therapies not specifically covered in this booklet.

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

Sexual dysfunction testing and treatment, unless related to organic disease or Accidental Injury.

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

Sperm storage is not a covered benefit under this Plan.

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

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

Thermography (a technique that photographically represents the surface temperatures of the body) is **not covered** under this Plan.
Transplants not specifically listed as a covered benefit under this Plan are **not covered**.

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

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

Unreasonable charges will not be covered by this Plan.

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

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

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

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

Vitamins, dietary supplements, special foods, formulas, or diets Nutritional supplements are not a covered benefit under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a covered benefit.

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

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

Weight loss programs, obesity treatment, and nutritional counseling, except as outlined in Section 4.

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

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

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (PHP may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

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

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

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

SECTION 6 – TERMINATION

HOW COVERAGE STOPS

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

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

If you are enrolled in the State of New Mexico Premium Only Plan (POP), coverage can be dropped only with an approved change in family status. (See Section 3 for additional details.)

If a Dependent becomes ineligible due to age, coverage ceases on 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 3rd Party Administer provides evidence of your prior health coverage by supplying you with a Certificate of Coverage.

LEAVE WITHOUT PAY

Employees on leave without pay must pay the full premium to keep this coverage in force. The State 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. 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 leave of absence and disability leave.

SECTION 6 – TERMINATION

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

CONTINUATION OF COVERAGE UNDER 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 State of New Mexico 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;

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;

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 within 31 days.

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 remarry and are covered under your new spouse's health plan unless the new plan contains an exclusion or limitation relating to any pre-existing condition you may have;
- You become entitled to Medicare benefits (coverage may continue for your spouse); or
- 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 19th through 29th month for a disabled person) of the full premium for your continuation coverage.

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

SECTION 6 – TERMINATION

COBRA AND THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

- The date you unequivocally inform 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; or
- The date the FMLA entitlement ends.

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

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

SECTION 7 – FILING CLAIMS

This is an HMO-type 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 Physicians 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. 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 Web site at www.phs.org or a Presbyterian Customer Service Center representative. Please mail the claim forms and itemized bills to:

PHP
Attn: STATE OF NEW MEXICO 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 Physician 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:

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

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

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

PRESCRIPTION DRUG CLAIMS

Claims for Prescription Drugs must be sent to the Prescription Drug Plan Administrator, **not** to PHP. Please refer to the Express Scripts Summary Plan Description or call them at 1-800-743-1720 for the claims filing procedures for Prescription Drugs.

HOW PAYMENTS ARE MADE

Payments for Covered Services usually are sent directly to In-network and National PPO Network Providers, including In-network and National PPO Network 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 National PPO Network agreements and the Negotiated Fee Schedule as determined by PHP. You are responsible for paying the Deductible and/or any Copayments, Co-insurance, and charges for non-Covered Services.

If you obtain services from an Out-of-network Provider, you are responsible for paying all Copayments, Co-insurance, 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 Physician 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.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

5. Active/Inactive Employee. If the Member who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active employee under one coverage and as the Dependent of the *same* but *inactive* employee under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

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

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

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

EFFECT OF MEDICARE ON BENEFITS

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

If you are a working employee age 65 or over or your spouse is age 65 or over, you are eligible to continue the State of New Mexico Plan coverage on the same basis as Members under age 65.

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

If Medicare coverage coexists with this Plan, Medicare will be secondary until the Plan pays primary for at least 30 months from the date the Member became eligible for or entitled to Medicare on the basis of end-stage renal disease. A person Eligible under Medicare is defined as an employee or Dependent who is enrolled and covered under the voluntary portion (Part B) of Medicare, or who has been eligible to enroll under such part. All individuals who are eligible to enroll for Medicare Part B but have not done so, will be treated the same as all other persons eligible under Medicare and PHP will assume that eligible Members have Part B coverage. Plan benefits will be offset with Medicare Part B benefits whether or not the Member actually receives them.

EFFECT OF MEDICAID ON BENEFITS

Benefits payable on behalf of a Member who is qualified for Medicaid will be paid to the Plan when:

- The Plan has paid or is paying benefits on behalf of the Member under the Group's Medicaid program pursuant to Title XIX of the Federal Social Security Act; and
- The payment for the services in question has been made by the Plan to the Medicaid Provider.

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

SUBROGATION

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

You have the legal obligation to help recover the amounts paid, and you must do nothing that would prejudice PHP's subrogation right. You must notify PHP if you file a claim, consult an

attorney, or bring action against a third party. If contacted by PHP, you must provide all requested information. Settlement of a controversy without prior notice to PHP is a breach of this agreement. In the event that you fail to cooperate with PHP or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of PHP, PHP may recover its benefit payments from you.

ASSIGNMENT OF BENEFITS

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

FRAUDULENT APPLICATION OR CLAIM

If you knowingly make a false statement on your enrollment Application or file a false claim, such Application or claim will be revoked retroactively back to the date of the Application or claim. Any premiums collected from the Member for coverage that is later revoked due to a fraudulent Application will be refunded to the Member by the Plan. If a claim is paid by PHP and it is later determined that the claim should not have been paid due to a fraudulent Application or claim, the Member shall be responsible for full reimbursement of the claim amount to PHP.

GRIEVANCE PROCEDURES

Overview
Many Grievances or problems can be handled informally by calling PHP at (505) 923-5600 or toll-free at 1-888-275-7737. Hearing impaired users may call our TTY line at 1-877-298-7407 or visit our website at www.phs.org. The Managed Health Care Bureau of the Office of Superintendent of Insurance (OSI) is also available to assist you with Grievances, questions or Complaints; call (505) 827-4601 or toll free at 1-855-427-5674

We (PHP) have established written procedures for reviewing and resolving your Grievances and concerns. There are two different procedures, depending on the type of Grievance. Any Member dissatisfied with a decision, action or inaction of ours, including a Termination of Coverage, has the right to request an internal review. You may submit your request verbally or in writing.

Adverse Determination: means a decision made either pre-service or post-service, by Presbyterian that a Health Care Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, does not meet Presbyterian's requirements for Coverage or Medical Necessity, and the requested HealthCare Service is denied, reduced or terminated.

Adverse Determination Grievance: means an oral or written complaint submitted by or on behalf of a Covered Person regarding an Adverse Determination.

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

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

Any Grievance may be submitted orally or in writing. If you make an oral Grievance, the Presbyterian Customer Service Center will assist you to complete the required forms. The Managed Health Care Bureau of OSI is also available to assist you. Please be advised that we shall not take any retaliatory action against you for filing a Complaint.

If your Grievance clearly contains administrative and adverse decision issues, then we will begin separate Grievances for each decision. When processing your Grievance, we will provide you with a detailed explanation of the Grievance procedure. The detailed explanation will tell you how we review and resolve Grievances, provide you with a toll-free telephone number, facsimile number, e-mail address, and mailing address of Presbyterian's Consumer Assistance Office.

You may request a copy and detailed written explanation of the Grievance procedures by calling the Presbyterian Customer Service Center at (505) 923-5600 or toll-free at 1-888-275-7737. Hearing impaired users may call our TTY line at 1-877-298-7407.

Members have 180 days from the date of the initial denial to file an Appeal with us.

Initial Determinations
When you or your treating healthcare professional requests a Health Care Service, we shall initially determine whether the requested Health Care Service is a Covered Benefit by your Health Benefits Plan. Before denying a Health Care Service for lack of Coverage, we will determine that there is no provision under which the requested Health Care Service could be Covered. If we find that the requested Health Care Service is not Covered, PHP will not review for Medical Necessity. If PHP finds that the requested Health Care Service is a Covered benefit, PHP will then determine if it is Medically Necessary. Before we deny a Health Care Service because of lack of Medical Necessity, our Medical Director will give an opinion as to Medical Necessity by either consulting relevant specialists or applying Uniform Standards that we use.

The initial determination must be completed within 24 hours where circumstances require expedited review, and five working days for all other cases. We may extend the review period for a maximum of 10 working days for pre-services cases if there is a demonstration of reasonable cause beyond control for the delay, the delay will not result in increased medical risk to you, and if a written progress report and explanation for the delay within the original five working day review period is sent to you.

An expedited decision will be granted whenever:

- The life or health of a Covered Person would be jeopardized.
- The Covered Person's ability to regain maximum function would be jeopardized.
- The Practitioner/Provider reasonably requests an expedited decision.

- The medical exigencies of the case require an expedited decision.

If our initial review results in the approval of the requested service, then we will notify you and your Practitioner/Provider of the approval by telephone or written correspondence within two working days of the date we approved the service.

If our initial review results in the denial, reduction or termination of the requested Health Care Service, then we will notify you and your doctor of the determination by telephone no later than twenty-four hours after making the initial decision. We will also notify you and your doctor of the initial decision in writing within one working day of the telephone notice. The written notice will state:

- If the decision is based on lack of Medical Necessity we will explain why the service is not Medically Necessary. A statement that the Health Care Service is not medically necessity is not sufficient.
- If the decision is based on lack of Coverage, all benefit plan provisions and materials will be cited completely explaining why the requested service is not a Covered Benefit. A statement that the requested Health Care Service is not covered by the Health Benefits Plan will not be sufficient.
- How you may request an internal review with us.
- Procedures and provide all the necessary forms you will need to request an internal review.

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

PHP, Inc.
Grievance Department
P.O. Box 27489
Albuquerque, NM 87125
(505) 923-5644 or toll-free at 1-800-356-2219
FAX (505) 923-5124
E-mail: gappeals@phs.org

You may also contact the OSI's Managed Health Care Bureau for assistance.

Adverse Determination Grievance Review Procedures
If you are dissatisfied with an Adverse Determination, you have the right to request an internal review by us. Once we receive your request for an internal review, we will date and time stamp your request and send you an acknowledgement letter within one working day. Our acknowledgement letter will tell you the name, address, and direct telephone number of the individual handling your request.

Our internal Adverse Determination Appeal Review Procedures require an initial review by one of our Medical Directors and then, if necessary, a second review by a medical panel. If your request was initially denied because of lack of Coverage, our Medical Director will review your Health Care Benefits Plan booklet to determine if there is any provision under which the requested Health Care Service could be Covered. If the initial request was based on lack of Medical Necessity, then our Medical Director will give an opinion as to Medical Necessity by either consulting relevant specialists or applying the Uniform Standards that we use. If our decision is

to approve the requested service, PHP will notify you and your Practitioner/Provider by telephone and written correspondence within two working days of the date we approved the service. Both reviews must be completed within seventy-two (72) hours when the circumstances require expedited review; or within thirty (30) working days for all cases in which the request for review is made prior to the service requested; and sixty (60) working days for all cases that involve post-service reviews if the Grievance contains clearly divisible administrative and adverse decision issues, then the Health Care Insurer shall initiate separate complaints for each decision. An expedited review is conducted when it is determined your life or health could be in jeopardy, or your ability to regain maximum function would be jeopardized. In an expedited review, all information will be transmitted between you and us by the most expeditious method available. If an expedited review is conducted during a Hospital stay or course of treatment, the Health Care Services will be continued without cost (except for applicable Cost Sharing Copayments, Co-insurance and Deductibles) to you until we make a final decision and notify you. We will not conduct an expedited review of an Adverse Determination made after Health Care Services have been provided to you. Presbyterian will work with you if an extension is needed – ten (10) working days for pre-service cases and twenty (20) working days for post-service cases. If you do not make an immediate decision to pursue the Grievance, or you request additional time to supply supporting documents or information, or postponement, the timeframes shall be extended to include the additional time requested by you. We must demonstrate a reasonable cause beyond control when requesting an extension. We will send you a written progress report explaining the reason for the delay. If we fail to comply with the deadline for completion of an internal review, the requested service may be approved unless you agree in writing to an extension.

If our Medical Director decides to uphold the denial, reduction or termination of the requested Health Care Service, then we will notify you of the Medical Director's decision by telephone and mail, and will ask you whether you want a second review by a medical panel that we select. If you indicate that you no longer wish to pursue the Grievance, we will mail to you a written notification of our decision and confirmation of your decision that you do not wish to pursue the matter further within three (3) working days of the Medical Director's decision. If we are unable to contact you by telephone within seventy-two (72) hours of making the decision to uphold, we will notify you by mail of the decision and will include a self-addressed stamped response form which asks whether you wish to pursue the Grievance further. The form will include a box for checking "yes" and a box for checking "no". If you do not return the response form within ten (10) working days, we will again contact you by telephone. If you do not respond to our telephone inquiries or return the response form, we will close the file including the documented efforts to contact you within twenty (20) working days. If the review is an expedited review, then we will select a medical panel to further review your request. We will not reasonably deny your request for a postponement of the internal panel review. The timeframes for internal panel review shall be extended during the period of any postponement.

If you indicate that you want a second review of your Appeal by a medical panel, then we will notify you of the date, time, and location of the medical panel review, and of your rights to participate in the review. No fewer than three (3) working days before the internal panel review, we will provide you with a copy of your appeal file. Pertaining to the internal panel review, you have the right to:

- Attend and participate in the internal panel review.
- Present your case to the internal panel.

- Submit any additional information before and at the internal panel review.
- Ask questions of any of the Presbyterian representatives including the internal panel.
- Be assisted or represented by a person of your choice, including legal representation (at your expense).
- Be advised if we will have legal representation at the hearing.
- Hire a specialist to participate in the internal panel hearing at your own expense, but the specialist may not participate in making the decision.

We will select one or more Health Care Professionals who have not been previously involved in your request to serve on the internal panel. At least one Health Care Professional selected will practice in a specialty that would typically manage the case related to your Grievance. Internal panel review Members will be present physically or by video or telephone conferencing to hear your Grievance. A panel Member who is not present to hear the Grievance either physically or by video or telephone conference shall not participate in the decision.

The internal review panel will review your Health Benefits Plan booklet to see if there is any provision under which the requested Health Care Service could be Covered. The internal review panel will give an opinion as to Medical Necessity by either consulting relevant specialists or applying Uniform Standards that we use.

No fewer than three (3) working days prior to the internal panel review, we will provide you with copies of the following:

- Pertinent medical records.
- Your Practitioner/Provider's recommendation.
- Your Health Benefits Plan booklet.
- All of our decision letters.
- Any Uniform Standards that we used.
- Any reports received from any medical consultants that we retained.
- All other evidence or documentation used in your review.

For an expedited internal review, all information will be provided to you by the most expeditious method available. If an expedited review is conducted during a Hospital stay or course of treatment, we will continue the Health Care Service (applicable Cost Sharing Copayments, Co-insurance and Deductibles apply) until we make a final decision.

Once the internal panel has made their decision, you will be notified within twenty-four (24) hours by telephone, and in writing within one (1) working day of the telephone notice. The written notice will include:

- The names, titles, and credentials of the internal review panel Members.
- A statement of the internal panel's understanding of the Grievance and all pertinent facts.
- The rationale for the internal review panel's decision including the following:
  - Identification of those provisions of your Health Benefits Plan booklet that we believe is relevant to the issue in the case under review and explain why each such provision did or did not support the panel's decision regarding coverage of the requested Health Care Service.

  - Citation to any Uniform Standards relevant to your medical condition and whether such standards support or do not support the panel's decision regarding the Medical Necessity of the requested service.
- Reference Uniform Standards relevant to the decision.
- Reference any other evidence or documentation used to make the decision.
- Your right to request an external review by the Superintendent of Insurance which will include the address and telephone number of the Managed Health Care Bureau of OSI and a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate the external review process.

External Review by the Superintendent of Insurance

If you are dissatisfied with the results of our review of an Adverse Determination, you may request an external review by the Superintendent by filing a written request within one-hundred and twenty (120) calendar days from the date you receive our decision. You may also file any other supporting documents or information to the Superintendent for review. If you wish to supply supporting documentation or information subsequent to the filing for an external review, the time frames for external review shall be extended up to ninety (90) days from the receipt of the complaint by the Superintendent, or until you submit all supporting documents, whichever occurs first. You may request the Superintendent extend your request if good cause is shown. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau—External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269.
- E-mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau at mhcb.grievances@state.nm.us.
- Fax to the Superintendent of Insurance, Attention Managed Health Care Bureau—External Review Request, at (505) 827-4253.
- Online by completing the OSI Managed Healthcare Complaint Form available at https://osi.state.nm.us/consumer-assistance/forms/managed-healthcare.html
- You or your Practitioner/Provider may request an expedited review by calling the Managed Health Care Bureau at (505) 827-3928 or1-855-427-5674.

You will need to provide a copy of our decision, a fully executed release form authorizing the Superintendent to obtain any necessary medical records from us or other Health Care Service Practitioner/Provider, and any other supporting documentation. If the Grievance involves an Experimental or Investigational Treatment Adverse Determination, provide a copy of your Practitioner's/Provider's certification and recommendation. You may contact the Managed Health Care Bureau to assist you in this process. The Superintendent may require you to exhaust any of our internal Grievance procedures before accepting a Grievance for external review.

Once your request for an external review is received, the Superintendent will send an acknowledgement that your request has been received. The Superintendent will also send us a copy of your external review request. Upon receipt of this request, we, within five (5) working days for standard review or the time limit set by the Superintendent for expedited review, will provide the Superintendent:

- Your *Summary of Benefits*.
- Your complete Health Benefits Plan booklet.

- All pertinent medical records, internal review decisions and rationales, consulting reports, and any documents and information submitted by you and us.
- Any Uniform Standards that we use.
- All evidence or documentation used in your internal review.

If we fail to comply with these Superintendent's requirements, the Superintendent may reverse our decision. The Superintendent may waive these requirements if the medical exigencies of the case deem it necessary.

The Superintendent will conduct either a standard or an expedited external review. The Superintendent will complete an expedited external review of your case no later than seventy-two (72) hours of receipt of the external review request. The OSI staff will complete the initial review of your case within ten (10) working days from receipt of your request for an external review. If you are granted an external review hearing, the Superintendent will complete the external review within thirty (30) working days from receipt of the complete request for external review. The Superintendent may extend the external review period for up to an additional ten (10) working days when deemed necessary.

Upon receipt of your request for external review, the OSI staff will review your request to determine whether:

- You have provided the necessary documents.
- You are or were a Covered Person under our Health Benefits Plan at the time the service was requested or provided.
- You have exhausted all of our internal review procedures.
- The requested service is a Covered Benefit under your Health Benefit Plan booklet.

The Division of Insurance staff shall attempt to informally resolve the Grievance in accordance with the procedures set forth in the New Mexico Administrative Code. If your external review request pertains to an Experimental or Investigational treatment, the OSI staff will also consider whether the requested service is a Covered Benefit, is not listed as an excluded benefit under your Plan and whether your doctor has certified that standard Health Care Services have not been effective or are not medically appropriate for you. The OSI staff will also consider whether there is no standard Health Care Service that we Cover that is as beneficial as, or more beneficial than the requested service.

If your request for external review is incomplete, the OSI staff will notify you and require you submit the additional information. If your request for an external review does not meet criteria, the Superintendent will notify you and us that your request will be denied. You have the right to request a hearing within thirty three (33) days from the date the notice was mailed to you. If the Superintendent determines your request for an external review is complete and meets the criteria, the Superintendent will notify you and us that your request meets criteria and an informal hearing will be scheduled. The notice of hearing will be mailed to you no later than eight (8) working days prior to the hearing date. The notice will tell you the date, time, place of the hearing, matters to be considered, and will advise you and us of your rights. The Superintendent will not unreasonably deny your request or our request for a postponement of the hearing.

The Superintendent may designate a Hearing Officer who will be an attorney licensed to practice in New Mexico. A Hearing Officer, independent Co-hearing Officer or ICO means a health care or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and Coverage issues that arise in external review hearings. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the OSI's expense. The Superintendent may also designate two (2) independent Co-hearing Officers who will be licensed Health Care Professionals. At least one of them will practice in a specialty that would typically manage the case related to your Grievance. Each Hearing Officer will disclose any potential conflicts of interest to the Superintendent. Any potential conflicts of interest can include personal or professional relationships to either you or us. The Superintendent will determine reasonable compensation for the appointed Hearing Officers and will annually publish a schedule of Hearing Officer's compensation in a bulletin. The Superintendent or attorney Hearing Officer may require additional information, may exclude any irrelevant evidence, may adjourn or proceed with the hearing if you or we fail to attend the hearing. Staff may attend the hearing, ask questions, and request evidence from the parties, but will not be present during deliberations between the Superintendent, his designated Hearing Officer, and any Co-hearing Officers. All testimony at the hearing will be taken under oath. The Superintendent or Hearing Officers may call and examine you, our designees, and other witnesses. The hearing will be recorded and you and we have the right to attend the hearing. You have a right to designate a person to attend on your behalf, be assisted or represented by an attorney and call, examine and cross-examine witnesses. You and we will each enter into record that the Hearing Officers will be released from civil liability for all communications, finding, opinions, and conclusions made during the external review process. At the close of the external hearing the Hearing Officers will review and consider your entire record and submit their decision to the Superintendent who will then render a decision in your case to include any further Grievance rights. If the decision requires action on our part, the order will state the timeframe for compliance. Once your external review is complete, the Hearing Officers will complete a compensation form indicating the amount of time spent participating in your external review. The completed forms will be submitted to the Superintendent and will be forwarded to us. We will compensate the Hearing Officers for time served within thirty (30) days of receipt.

The Superintendent's order will be binding to both you and us and will state that both you and PHP have the right to judicial review pursuant to New Mexico Statutes as state and federal law may provide other remedies. You or we cannot file a subsequent request for external review of the same Adverse Determination that was the subject of the Superintendent's order.

Administrative Grievance Procedures

If you are dissatisfied with a decision, action or inaction of ours regarding a matter that does not involve the denial, reduction or termination of a requested Health Care Service, then you have the right to request, orally or in writing, that we internally review the matter. Once we receive your request for an internal review, we will date and time stamp your request and send you an acknowledgement letter within three (3) working days. Our acknowledgement letter will tell you the name, address, and direct telephone number of the individual handling your request. Your request will be conducted by our representative who will allow you to present any information related to your case and who will take corrective action if necessary. We will review the Grievance

and provide you with a written decision within fifteen (15) working days from receipt of the Grievance. We will notify you if an extension is necessary. An extension may be granted when there is a delay in obtaining the documents or records necessary to appropriately review your Grievance. We will notify you in writing of the reasons for the extension and the expected date of resolution. Your written decision will include:

- The name, title, and qualifications of the person conducting the initial review.
- A statement of the reviewer's understanding of the Grievance and all pertinent facts.
- The rationale for the decision.
- Every relevant provision of your Health Benefits Plan booklet.
- Reference Uniform Standards relevant to the decision.
- Reference any other evidence or documentation used to make the decision.
- Your right to request a reconsideration within twenty (20) working days including all necessary forms.

If you are dissatisfied with this decision, you may file a written request for our reconsideration. We will appoint a reconsideration committee, consisting of one or more employees of the Plan who were not involved in the initial decision, to review the Grievance and will schedule a hearing. The hearing shall be held during regular business hours at a location reasonably accessible to the Grievant, and we shall offer the Grievant the opportunity to communicate with the committee, at our expense, by conference call, video conferencing, or other appropriate technology. We shall not unreasonably deny a request for postponement of the hearing made by a Grievant. We will notify you of the date, time and location of the hearing and your rights in this process within 10 working days after your hearing request is received. No fewer than three working days prior to your hearing, we will send you all the documents and information the committee will be reviewing. The reconsideration committee hearing will be held within fifteen working days after your hearing request is received. We will mail you a written decision within 7 working days after the hearing.

Pertaining to the reconsideration committee review, you have the right to:

- Attend and participate in the reconsideration committee review.
- Present your case to the internal panel.
- Submit any additional information before and at the reconsideration committee review.
- Ask questions of any of our representatives including the internal panel.
- Be advised if we will have legal representation at the hearing.
- Be assisted or represented at your expense by a person of your choice.

You will be mailed a written decision within seven (7) working days after the reconsideration committee hearing. Your written decision will include:

- The names, titles and qualifications of the reconsideration committee panel.
- The committee's statement of the issues involved in your Administrative Grievance.
- An explanation of the rationale of the committee's decision.
- References to the evidence or documentation used to make the decision.
- A statement that the initial decision will be binding unless you submit a request for an external review by the Superintendent within twenty (20) working days of receipt of the reconsideration decision.
- Instructions, procedures and forms on how to submit the Administrative Grievance to the Superintendent including address and toll-free telephone number.

External Review by the Superintendent of Insurance
If you are dissatisfied with the results of the review by our reconsideration committee, you may request an external review by the Superintendent by filing a written request within twenty (20) working days from the date you receive our decision. You may also file any other supporting documents or information to the Superintendent for review. If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the time frames for external review shall be extended up to ninety (90) days from receipt of the complaint form by the Superintendent, or until you submit all supporting documents, whichever comes first. You may file your request for external review on the forms we provided by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau—External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269.
- E-mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau at mhcb.grievances@state.nm.us.
- Fax to the Superintendent of Insurance, Attention Managed Health Care Bureau—External Review Request, at (505) 827-4253.
- Online by completing the OSI Managed Healthcare Complaint Form available at https://osi.state.nm.us/consumer-assistance/forms/managed-healthcare.html.

The Superintendent may require you to exhaust any of our internal Grievance procedures before accepting a Grievance for external review.

Once your request for an external review is received, the Superintendent will send an acknowledgement that your request has been received. The Superintendent will also send us a copy of your external review request. Upon receipt of this request, we, within five (5) working days for standard review or the time limit set by the Superintendent for expedited review, will provide the Superintendent:

- Your *Summary of Benefits*.
- Your complete Health Benefits Plan booklet.
- All pertinent medical records, internal review decisions and rationales, consulting reports, and any documents and information submitted by you and by us.
- Any Uniform Standards that we use.
- All evidence or documentation used in your internal review.

The Superintendent will review the documents submitted by you and by us and may conduct an investigation or inquiry with the Grievant. The Superintendent will issue a written decision to you within 20 working days of receipt of the external review request.

Retaliatory Action
In accordance with the federal Patient Protection and Affordable Care Act, and the New Mexico Administrative Code's Grievance Procedures Rule, we cannot take retaliatory action against you for filing a Grievance under this Health Benefits Plan.

Confidentiality of a Covered Person

In accordance with the New Mexico Administrative Grievance Procedure Rule, Health Care Insurers, the Superintendent, independent Co-hearing Officers, and all others who acquire access to identifiable medical records and information of Covered Persons when reviewing Grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

SECTION 8 – MEMBERS 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 health care 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 health care, with limits on out-of-pocket expenses.

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

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

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

10. change Primary Care Physicians by following the rules described in this booklet.

11. participate with Providers in decision making regarding their health care.

12. clear and candid discussion of Medically Necessary treatment options, regardless of benefit coverage or cost.

13. all the rights afforded by law, rule or regulation as a patient in a licensed health care facility, including the right to refuse care, treatment, or medications after the Practitioner has explained the care, treatment or other advice in language the Member understands.

14. refuse the care of a specific Practitioner.

15. 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 primary or treating Provider, in consultation with the Claim Administrator, 24 hours per day, seven days a week for urgent or Emergency Care services, and for other health services as defined by this booklet.

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.

SECTION 8 – MEMBERS RIGHTS AND RESPONSIBILITIES

Member Responsibilities:

All Members must:

1. review this booklet and if there are questions contact the Presbyterian Customer Service Center at 505-923-5600 or toll-free at 1-888-275-7737 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.

9. pay all required Copayments and/or Co-insurance at the time services are rendered.

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

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

GLOSSARY OF TERMS

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

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

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

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

AMBULANCE SERVICE means a duly licensed transportation service, capable of providing Medically Necessary life support care in the event of a life-threatening situation.

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

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

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

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

PRIOR AUTHORIZATION means the process whereby PHP or PHP's delegated Provider contractor reviews and approves, in advance, the provision of certain Covered Services to Members before those services are rendered. If you obtain services from an In-network Provider, they will request Prior Authorizations from PHP. If you obtain services from a National PPO

Network Provider, then it is your responsibility to obtain Prior Authorization. Failure to obtain Prior Authorization before obtaining services may result in an additional monetary penalty or denial of benefits. If a required Prior Authorization is not obtained for services rendered by a Out-of-network Provider, the Member may be responsible for the resulting charges. Prior Authorization is used in the management of health care needs; Services rendered beyond the scope of the Prior Authorization may not be covered.

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

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received during a Calendar Year that is the Member's responsibility. This amount includes Copayments, (except Pharmacy Copayments), Co-insurance, and Deductible for PCP and Specialist services.

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

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

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

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

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

COSMETIC SURGERY means Surgery that is beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic. It is performed to reshape normal structures of the body in order to improve appearance and self-esteem.

COVERED SERVICES means services or supplies specified in this SPD, including any supplements, endorsements, addenda, or riders, for which benefits are provided, subject to the terms, conditions, limitations, and exclusions of this SPD.

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

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

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

DEPENDENT means any Member of a covered employee's family who meets the requirements of Section 3 of this SPD and is actually enrolled in the Plan.

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

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

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

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

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

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

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

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); or
- disorders of fat metabolism.

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

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

HEALTH CARE PROFESSIONAL means a Physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

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

HIPAA means Health Insurance Portability and Accountability Act.

HOME HEALTH AGENCY means an appropriately licensed Provider that both:

- Brings skilled nursing and other services on an intermittent, visiting basis into the Member's home in accordance with the licensing regulations for home health agencies in New Mexico or in the locality where the services are administered; and
- Is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the Attending Physician.

HOSPICE means a duly licensed program or facility providing care and support to terminally ill patients and their families.

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

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

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

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

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

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

GLOSSARY OF TERMS

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

LICENSED NAPRAPATHIC means a naprapathy practitioner who is licensed by the appropriate state authority. Certification alone does not meet the licensure requirement.

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

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

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

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

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

MEDICAL EMERGENCY means an Accidental Injury or a condition that occurs suddenly and unexpectedly and is life threatening or could result in permanent damage if not treated immediately. To be eligible for possible emergency benefits, the Member must seek treatment within 48 hours of the Accidental Injury or onset of the condition.

MEDICAL NECESSITY OR MEDICALLY NECESSARY means Health Care Services determined by a Provider, in consultation with the healthcare insurer, to be appropriate or necessary, according to any applicable generally accepted principles of good medical practice and practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and 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 or Mental Health condition, illness, injury, or disease.

MEDICARE means the program of health care for the aged, end-stage renal disease (ESRD) beneficiaries, and disabilities established by Title XVIII of the Social Security Act of 1965, as amended.

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

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

MENTAL DISORDER means a behavioral or psychological syndrome that causes significant distress (a painful symptom) or disability (impairment in one or more important areas of functioning), or a significantly increased risk of suffering death, pain, or an important loss of freedom. The syndrome is considered to be a manifestation of some behavioral, psychological, or biological dysfunction in the person (and in some cases it is clearly secondary to or due to a general medical condition). The term is not applied to behavior or conflicts that arise between the person and society (e.g., political, religious, or sexual preference) unless such conflicts are clearly an outgrowth of a dysfunction within that person. In lay usage, "emotional illness" serves as a term for mental disorder, although it may imply a lesser degree of dysfunction, whereas the term "mental disorder" may be reserved for more severe disturbances.

NEGOTIATED FEE SCHEDULE means the contracted amount that PHP agrees to pay to In-network Providers for Hospital, professional services, and other charges, and for which In-network Providers agree to accept as payment for services rendered to Members.

OUT-OF-NETWORK PROVIDER means a duly licensed healthcare Provider, including medical facilities which has no agreement with PHP for reimbursement of services to Members.

OBSERVATION means those furnished by a Hospital and practitioner on the Hospital's premises, which may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible Admission to the Hospital as an Inpatient, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under Outpatient Observation stay, it is on the practitioner's written order. If not formally admitted as an Inpatient, the patient initially is treated as an Outpatient. The Member does not meet Inpatient Admission criteria as identified in the PHP designated level of care criteria regardless of the length of time spent in the Hospital.

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

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

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

- An institution or entity only listed as:

- Ambulance Provider
- Ambulatory Surgical Facility
- Birthing Center
- Durable Medical Equipment Supplier
- Freestanding Dialysis Facility
- Home Health Agency
- Hospice Agency
- Independent Clinical Laboratory
- Pharmacy
- Rehabilitation Hospital
- Urgent Care Facility

- A person or practitioner only listed as:
  - Certified Nurse Midwife
  - Certified Registered Nurse Anesthetist
  - Chiropractor
  - Dentist
  - Licensed Acupuncturist
  - Licensed Practical Nurse
  - Occupational Therapist
  - Physical Therapist
  - Podiatrist
  - Licensed Lay Midwife
  - Registered Nurse
  - Respiratory Therapist
  - Speech Therapist

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

IN-NETWORK PROVIDER means Physicians, Hospitals, and other Healthcare Professionals, facilities, and suppliers that have contracted with PHP as In-network Providers.

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

PHYSICIAN means a duly licensed practitioner of the healing arts acting within the scope of his/her license.

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

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

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

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

PRIMARY CARE PHYSICIAN (PCP) means a duly licensed Doctor of Medicine or Osteopathy, formally selected by the Member to assume primary responsibility for his/her care.

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

PROVIDER means a duly licensed Hospital, Physician, or Other Provider performing within the scope of the appropriate licensure.

REASONABLE CHARGE OR REASONABLE AND CUSTOMARY (R&C) CHARGE means the amount determined to be payable by PHP for services rendered to Members by Out-of-network Providers, based upon the following criteria:

- Fees that a professional Provider usually charges for a given service;
- Fees which fall within the range of usual charges for a given service filed by most professional Providers in the same locality who have similar training and experience; and
- Fees which are usual and customary or which could not be considered excessive in particular case because of unusual circumstances.

REGISTERED LAY MIDWIFE means a person licensed by the state to provide Health Care Services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

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

REHABILITATION HOSPITAL means an appropriately licensed facility that, for compensation from its patients, provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by illness or Accidental Injury to achieve the highest

possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

RESIDENTIAL TREATMENT CENTER means a facility licensed to provide Residential Treatment (to include room and board) where the primary services are behavioral health treatment provided under the supervision of a psychiatrist in a facility to individuals with behavioral health disorders but whose condition does not require care in an acute Hospital facility

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

SEMI-PRIVATE means a two or more bed Hospital room, skilled nursing facility or other healthcare facility or program.

SERVICE AREA means the entire state of New Mexico.

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

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

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

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

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

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

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

SUBSTANCE ABUSE means impairment in social and occupational functioning resulting from the pathological and "compulsive" use of a substance. The concept is closely related to the

definition of substance dependence, which has similar *symptoms* of impairment by may include evidence of physiological *tolerance or withdrawal*. Typical symptoms of abuse include a failure to fulfill major role obligations at work, school, or home; recurrent use of the substance in situations where such use is physically hazardous; substance-related legal problems; and continued use even though it cause or exaggerates interpersonal problems.

SUBSTANCE DEPENDENCE or Chemical Dependence – Sometimes defined in terms of physiological dependence as evidenced by *tolerance or withdrawal*; at other times defined in terms of impairment in social and occupational functioning resulting from the pathological and repeated use of a substance. In the latter, tolerance and withdrawal symptoms may be present but are not essential.

The behaviors and effects associated with substance dependence include taking the substance to relieve or avoid withdrawal symptoms; taking of larger amounts or using over a longer period than intended; unsuccessful efforts to cut down or control intake; interference with meeting major role obligations at work, school, or home; recurrent use in situations when it poses a physical hazard (e.g., driving, operating machinery); or substance use taking precedence over important social, occupational, or recreational activities.

SUMMARY PLAN DESCRIPTION (SPD) means this booklet.

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

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

TEFRA means Federal law regarding the working aged.

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

TWO-PARTY COVERAGE means coverage for the employee and his/her spouse, or coverage for the employee and one Dependent child.

URGENT CARE means Health Care Services provided by an Urgent Care Facility in emergencies.

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

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

Acceptance Page

State of New Mexico agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the State of New Mexico HMO Plan.

By:

Cynthia Archuleta 3/28/19