NEW MEXICO RETIREE HEALTH CARE AUTHORITY
Member Benefit Booklet

PPO Medical Plan
Plan Code: HWP10018
EFFECTIVE: January 1, 2019

Offered by New Mexico Retiree Health Care Authority (NMRHCA)
Administered by Presbyterian Health Plan, Inc.

WELCOME

The New Mexico Retiree Health Care Authority (referred to as NMRHCA) is pleased to present your Plan effective January 1, 2019. You will notice some differences from plans offered in the past, and this *Member Benefit Booklet* provides a good explanation of how to maximize the Plan's benefits.

As you are aware, health care costs continue to increase at an alarming rate and NMRHCA is not immune to the contributing factors behind these increases. However, through sound administrative practices as well as good decisions on your part as Plan participants, NMRHCA has been able to limit the impact to its Plan participants.

In keeping with its commitment to service and flexibility, NMRHCA is offering plans that provide you with options for accessing care. NMRHCA believes that your engagement as a well-informed care seeker will help ensure the long-term success of the Plan. In partnership with NMRHCA, we encourage you to familiarize yourself with the Plan's features in order to make informed decisions about your healthcare.

This *Member Benefit Booklet* is intended to provide you with easy-to-understand explanations about specific provisions of the program including covered services and related out-of-pocket expenses.

While every effort is made to make this booklet as accurate as possible, any conflict that should arise between this *Member Benefit Booklet* and the claims administrator will be governed by the terms of the Professional Services Agreement. Additionally, NMRHCA reserves the right to terminate, discontinue, alter, modify, or change this Plan or any provision of this Plan at any time.

Please take time to read and understand the terms and conditions in this *Member Benefit Booklet* in order to better understand the costs associated with the delivery of care.

Thank you for the opportunity to serve you.

New Mexico Retiree Health Care Authority

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SUMMARY OF BENEFITS

The following highlights the PPO plans administered by Presbyterian Health Plan, Inc.(Presbyterian Health Plan) for New Mexico Retiree Health Care Authority members statewide. These benefits are effective 1/1/19 through 12/31/19. The specific terms of coverage, limitations and exclusions are detailed in Sections 4 and 5 of the Summary Plan Description.

PRESBYTERIAN		Premier Option	
		In-Network Care	**Out-of-Network**
	Annual Deductible (Deductible must be met before payments are made and applies to all services otherwise indicated.)	$800	
	Annual Out-of-Pocket Max (Does not include penalty amounts, charges above Reasonable and Customary or non-Covered charges including charges incurred after the benefit maximum has been reached.)	$4,500	
	Lifetime maximum	Unlimited (Certain services are subject to Calendar Year and/or lifetime maximums or are limited per condition.)	
Physician Services	**Office Services**		
	Office Visit (Deductible waived In-network only- other services received during the office visit, such as therapy or Surgery, are subject to Deductible and Coinsurance as listed in the rest of the summary)	$30 copay	50%
	Office Services Specialist (Deductible waived for in-network providers)	$45 copay	50%
	Allergy Injections, Tests, Serums	25%	50%

SUMMARY OF BENEFITS

PRESBYTERIAN		Premier Option	
		In-Network Care	**Out-of-Network**
Physician Services *continued*	**Preventive services** Women's Health Care Contraceptive Methods • Intrauterine Devices (IUD) • Hormone Contraceptive Injections • Inserted Contraceptive Devices • Implanted Contraceptive Devices Breastfeeding support, supplies and counseling (for one year after delivery) Related Testing (including routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc., and immunizations.)	Plan pays 100%	50%
Outpatient Diagnostic Testing	PET[1], MRI[1], CT Scans[1] In Free Standing Imaging Center (Deductible waived)	25% $100 per test, per day	50% 50%
	Laboratory, X-rays, and Pathology (Deductible waived)	Plan pays 100%	50%
	EKG	25%	50%
	Home/Sleep Studies	25%	50%
Hospital Services	**Hospitalization** Medical/Surgical and Maternity Related Room and Board and Covered Ancillaries[2] Physicians and other Professional Provider Charges	25% 25%	50% 50%
	Inpatient rehabilitation services[1,2]	25%	50%
Surgical Services	Inpatient Surgery[1,2]	25%	50%
	Outpatient Surgery[1,] (Except for specific listed services below)	25%	50%

SUMMARY OF BENEFITS

PRESBYTERIAN		Premier Option	
		In-Network Care	**Out-of-Network**
Surgical Services Continued	Outpatient Surgery[1] for the facilities and services detailed below: In-Network Deductible Waived Presbyterian (Kaseman Hospital Albuquerque, Rust Medical Center Rio Rancho) • Hernia • Laparoscopic Cholecystectomy Surgery New Mexico Orthopedics (Albuquerque) • Shoulder Arthroscopy • Knee Arthroscopy	$500	50%
	Office Surgery (including casts, splints, and dressings)[1]	25%	50%
Maternity Services	Physician/midwife services (delivery, prenatal, postnatal care)	25%	50%
	Hospital Admission[1,2]	25%	50%
	Routine nursery care for newborns	25%	50%
Urgent and Emergency Services	Urgent Care Facility (Deductible waived In-network only)	$35 copay	50%
	Emergency room visit/Observation room treatment (Deductible waived)	$125 copay	$125 copay
	Physician and Other Professional Provider Charges[3])	25%	25%
	Ambulance Services	25%	25%
	Emergency Air Transport	25%	25%
Mental Health	Outpatient services[1] (first visit will be Covered at 100% per calendar year)	$30 copay	50%
	Inpatient services[1,2]	25%	50%
Substance Abuse	Outpatient services[1]	$30 copay	50%
	Inpatient services[1,2]	25%	50%

PRESBYTERIAN		Premier Option	
		In-Network Care	In-Network Care
Other Services	Alternative therapy (e.g. Acupuncture, Chiropractic, Massage therapy, and Rolfing) ***($1,500 combined In-Network and Out-of-Network Calendar Year maximum)*** [5]	25%	50%
	Cardiac or Pulmonary Rehabilitation – Outpatient	25%	50%
	Chemotherapy and/or Radiation Therapy	25%	50%
	Dialysis	25%	50%
	Biofeedback	25%	50%
	Durable Medical Equipment[1,4] Prosthetics and Orthotics[1]	25% 25%	50% 50%
Other Services *(Continued)*	Hearing Aids – (Deductible waived) Benefits are limited. Please see "Hearing Aids" under Durable Medical Equipment subsection of Section 4 - Covered Services for details on this benefit.	No copay	No copay
	Home health care[1]	25%	50%
	Hospice[1] Bereavement counseling ***(limited to 3 sessions during the Hospice benefit period)*** Respite care ***(limited to 10 continuous days and no more than 2 respite stays allowed during a 6-month Hospice benefit period)***	25%	50%
	Physical, Occupational and Speech Therapy[1,2] If PT obtained as alternative to surgery (Maximum of 4 copayments per course of treatment) (Deductible waived)	25% $30 copay	50% 50%
	Dialysis/Plasmapheresis/ Photopheresis	25%	50%
	Skilled Nursing Facility[1,2] ***(limited to 60 days per Calendar Year)***	25%	50%

	Smoking cessation (Deductible waived)	Plan pays 100%	Plan pays 100%
Transplants	Coverage for human organ transplants[1,2] (refer to *Member Benefit Booklet* for complete details on transplant coverage)	25%	**No benefit**
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at **1-800-501-0987.**		

The Deductible must be met before benefit payments are made. (Deductible may be waived for routine/preventive services, drugs and other services as indicated on the *Summary of Benefits*.)

After Member reaches the applicable Out-of-Pocket Maximum, the Plan pays 100% (up to Reasonable and Customary for Out-of-network Providers) of most of that Member's covered charges.

Footnotes:

[1] Certain services are **not Covered** if prior approval is not obtained from the plan administrator. See Section 2 of the Member Benefit Booklet for a list of services requiring prior approval.

[2] Admission review is required for Inpatient Admissions. You pay a $300 penalty for Covered medical/surgical facility services if approval is not obtained. (This penalty applies only to services provided by an Out-of-network Provider.) Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related Admissions will be denied. See Section 2 of the Member Benefit Booklet for details.

[3] Initial treatment of a Medical Emergency is paid at In-network Provider level. Follow-up treatment from an Out-of-network Provider and treatment that is not for an emergency is paid at Out-of-network Provider level. The Emergency Room copayment does not include related physician charges (which will be subject to deductible and coinsurance). The Emergency Room/Observation Room copay is waived if the Member is subsequently admitted.

[4.] Rental benefit for medical equipment and other items will not exceed the purchase prices of a new unit.

[5] Services administered by a licensed medical doctor (M.D.), doctor of osteopathy (D.O.), physical therapist (R.P.T. or L.P.T.), licensed massage therapist (L.M.T.), doctor of oriental medicine (D.O.M.), and doctor of chiropractic (D.O.C.) are Covered. Rolfing must be provided by a certified Rolfer.

SECTION 1 – INTRODUCTION

INTRODUCTION

The New Mexico Retiree Health Care Authority provides group health care coverage through the Preferred Provider Organization (PPO) Medical Plan (Plan) administered by Presbyterian Health Plan, Inc. (Presbyterian Health Plan (PHP))

This booklet is your *Member Benefit Booklet.* 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 *Member Benefit Booklet*:

- Providers are Physicians, Hospitals, and other Health Care Professionals or facilities that provide Health Care Services.
- In-network Providers have contractual agreements with Presbyterian Health Plan, Inc., and allow lower out-of-pocket expenses and additional benefits for covered persons.
- Out-of-network Providers do not have contractual agreements with Presbyterian Health Plan, Inc.; this may increase the out-of-pocket expenses and limit benefits for covered persons.

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

SECTION 2 – HOW THE PLAN WORKS

HOW THE PLAN WORKS

Your group health care plan is a Preferred Provider Organization (PPO) benefit Plan administered by the Claims Administrator, Presbyterian Health Plan, Inc. (Presbyterian Health Plan). This plan is available only to those Members living in New Mexico.

This PPO Plan allows you to choose, at the time you receive services, the level of benefits that will apply. **You receive the highest benefit level with the lowest cost to you when you obtain services from an In-network Provider.** The Presbyterian Health Plan Provider Directory lists the In-network Providers. The provider directory is available through the Presbyterian Website at **www.phs.org**, or you can obtain one by calling the Presbyterian Customer Service Center, Monday through Friday, between 7 a.m. and 6 p.m. at (505) 923-5600 (in Albuquerque), or toll free at 1-888-275-7737 (Ask-PRES). TTY users may call 711.

In-network Providers

As a Member of this PPO, for payment to be made you will generally **not** have claims to file or papers to fill out in order to be reimbursed for medical services obtained from In-network Providers. Your In-network Providers will bill Presbyterian Health Plan directly. Most doctor visits and Hospital Admissions, however, do require Copayments and/or Coinsurance at the time of service. Coinsurance is the percentage of Covered charges that you must pay for Covered Services after the Deductible has been met. The amount of your Coinsurance and/or Copayment for each service is located in the *Summary of Benefits* section of this document. The Coinsurance will be applied to the Total Allowable Charges or billed charges, whichever is less, for the particular procedure allowed by the Plan.

Out-of-network Providers

Out-of-network services, as shown in the *Schedule of Benefits*, apply when you obtain care from a Provider who is **not** an In-network Provider**.**

If you choose to receive care from Providers who are Out-of-network, payments by Presbyterian Health Plan for Covered Services will be **limited** to Reasonable and Customary Charges (the only exception will be for emergency services). You will be responsible for any balance due above the Reasonable and Customary Charges, in addition to any applicable Deductible or Coinsurance. Out-of-network Providers may require you to pay them directly at the time of service; you will then have to file your claim for reimbursement with Presbyterian Health Plan. Refer to the Claims Section of this document for more information on submitting such a claim.

Some services are **not Covered** when received from an Out-of-network Provider. Please refer to your *Schedule of Benefits* and throughout this document for a complete listing of Covered Services.

What is Prior Authorization?

Prior Authorization can provide you with the assurance that when you are using the Plan you are being treated in the most efficient and appropriate health care 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.

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

- In-network Provider - When accessing services from an In-network Provider, the In-network Provider is responsible for obtaining Prior Authorization from Presbyterian Health Plan before providing these services to you.
- Out-of-network Provider - When accessing services from an Out-of-network Provider, you are responsible for obtaining Prior Authorization from Presbyterian Health Plan before obtaining the Out-of-network services. If Prior Authorization is **not** obtained when required, then the services may **not be Covered** by the Plan and payment will be your responsibility.

What procedures require Prior Authorization?

Prior Authorization is required for the following services. If you obtain services from an Out-of-network Provider, it is your responsibility to verify that an authorization has been obtained. Services of an Out-of-network Provider may not be Covered without a written **Prior Authorization**.

Prior Authorization - Inpatient

If an In-network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, the In-network Provider is responsible for any **Prior Authorization** requirement for Inpatient Admissions. If an Out-of-network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, you are responsible for any **Prior Authorization** requirement for Inpatient Admissions. Failure to obtain Prior Authorization for admission by an Out-of-network Provider may result in a reduction in benefits of $300. If you are hospitalized and there has been no approved **Prior Authorization**, and the Plan determines that the Admission was not Medically Necessary, **no** benefits are paid for Inpatient room and board charges. Additionally, these expenses do **not** apply toward the Out-of-Pocket Maximum provision. Other Covered Services are paid as explained in the *Schedule of Benefits* and Section 4. If the Admission is not for a Covered Service, **no** payment is made.

Note:
All Admissions for Behavioral Health and Alcoholism and/or Substance Abuse services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department (1-800-453-4347). If Prior Authorization is not obtained prior to rendering service, they may not be Covered if they do not fall within the benefits and limitations of this Plan. For emergencies, Presbyterian Health Plan Behavioral Health 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.

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 also required for the following services. For certain services, **Prior Authorization** may be requested over the telephone. In other cases, a written request for approval must be submitted.

If **Prior Authorization** is not obtained for the following services, benefits will be reduced or denied for all related services. Your In-network Provider will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorizations** with your Provider before obtaining any of the following services:

- Cancer Clinical Trials;
- Certain injectables received in the provider's office;
- Computed Axial Tomography (CAT/CT) Scans;
- Detoxification (acute requiring medical intervention);
- Durable Medical Equipment, Orthotic and Prosthetic Devices (also see the Express Scripts Prescription drug coverage booklet or call them at 1-800-501-0987);
- Home health care;
- Hospice;
- Hospital Admissions;
- Mental Health and Substance Abuse (All non-emergency Inpatient);
- Morbid Obesity;
- MRIs;
- Observation more than 24 hours;
- Podiatric and Orthopedic Appliances
- Positron Emission Tomography (PET) Scans;
- Reconstructive Surgery;
- Repair or replacement of non-rental DME;
- Selected Surgical Procedures;
- Skilled Nursing facilities; and
- Transplants.

Case Management Program

Presbyterian Health Plan's Case Management Program identifies, as early as possible, 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 the Presbyterian Customer Service Center,

Monday through Friday, between 7 a.m. and 6 p.m. at (505) 923-5600 (in Albuquerque), or toll free at 1-888-275-7737 (Ask-PRES) 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 *Schedule of Benefits.*

Copayment
For some services, you pay a Copayment and the Plan pays the remainder. The Copayment is stated as a set dollar amount. See the *Schedule of Benefits* for all applicable Copayments.

Coinsurance
For many services, you will pay a Coinsurance. 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 Coinsurance is in addition to the annual Deductible you are responsible for and continues to be your responsibility after the annual Deductible is met. See the *Schedule of Benefits* for Coinsurance amounts.

Annual Deductible
Most services are subject to an annual Deductible. The amount of your annual Deductible is located in the *Schedule of Benefits*. 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 (excluding preventive services, drugs, items Covered under the prescription drug plan and other services as indicated on the *Schedule of Benefits*.)

Annual Out-of-Pocket Maximum
This Plan includes an Annual Out-of-Pocket Maximum amount to protect you from catastrophic health care expenses. After your Annual Out-of-Pocket Maximum is reached in a Calendar Year, the Plan pays 100%, up to Reasonable and Customary Charges, for Covered Services for the remainder of that Calendar Year, up to the maximum benefit amounts if any. Refer to the *Schedule of Benefits* for the Annual Out-of-Pocket Maximum amounts.

The Annual Out-of-Pocket Maximum includes Deductible, Copayments and Coinsurance. It does **not** include penalty amounts, non-Covered charges, any amounts over Reasonable and Customary charges, or Prescription Drug Copayments.

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

Medical Necessity
The Plan helps pay health care expenses that are Medically Necessary and for those routine services specifically Covered in this *Member Benefit Booklet*. **No** benefit is available for any expense that is not Medically Necessary, unless it is for a routine service specifically Covered in this *Member Benefit Booklet.*

To be Medically Necessary, tests, treatments, services, or supplies provided by a Hospital, physician, or other health care Provider must:

- Be appropriate for the symptoms or diagnosis and treatment of the Member's condition, disease, illness or Accidental Injury;
- Be provided for the diagnosis or the direct care and treatment of the Member's condition, disease, illness or Accidental Injury;
- Be in accordance with the standards of good medical practice in the state where services are provided;
- Not be primarily for the convenience of the Member, the Member's family, or the Member's Provider; and
- Be the most appropriate supply or level of service that can safely be provided to the Member. When applied to hospitalization for acute care, this further means that the Member requires acute care as a bed patient and cannot receive safe or adequate care in a skilled facility, home health care or Outpatient.

Presbyterian Health Plan determines whether a health care service or supply is Medically Necessary, and therefore, whether the expense is Covered. (Note: If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a Grievance or complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievances" in Section 6.) The fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it Medically Necessary or make the expense a Covered Service, even though it is not specifically listed as an exclusion.

Health Care Fraud Message

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

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

If you suspect fraud, please call the Presbyterian Customer Service Center, Monday through Friday, between 7 a.m. and 6 p.m. at (505) 923-5600 (in Albuquerque), or toll free at 1-888-275-7737 (Ask-PRES). TTY users may call 711.

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Eligibility

Each person who becomes eligible for coverage can apply by submitting an Application to NMRHCA **within 31 days** of becoming eligible. Call NMRHCA at 1-800-233-2576 for more information. Eligibility conditions are mandated by the Retiree Health Care Act and are subject to periodic changes.

Coverage Types

Single (individual) – Retiree or his or her Dependent is covered.

Dependents are allowed to be covered under a non-Medicare plan when the retiree (or a surviving spouse) is covered under a NMHRCA sponsored Medicare program.

Late Applicants

NMRHCA is no longer accepting "late applicants" into the program unless the applicant has experienced a qualifying event according to Section 125 of the Internal Revenue Service (IRS) Code.

NMRHCA will allow an "open enrollment period" once every other year beginning January 1, 2017.

Eligible Retiree, Spouse, Dependent Change in Status/Enrollment

When an eligible retiree, spouse, or Dependent was receiving or eligible to receive group health benefit coverage through a third party and because of a change in status lose the coverage and become ineligible for the coverage, he/she may enroll in any NMRHCA Plan without submitting a health statement. In such cases, if the loss of coverage was not caused by any neglect or wrongdoing by the eligible retiree, spouse, or Dependent, he/she may enroll **within 31 days** of the change of status without being considered a late applicant.

Eligible Retiree

You are an *eligible retiree* (a retiree eligible to participate in NMRHCA) if:

- You receive a disability or normal retirement benefit from public service in New Mexico with an NMRHCA-participating employer, **and** you did one of the following:
  - You retired with a pension before your employer's effective date with NMRHCA program;
  - You and/or your employer (on your behalf) made contributions to NMRHCA fund from your employment effective date with NMRHCA until your date of retirement;
  - You and/or your employer (on your behalf) made contributions to NMRHCA fund for at least five years before your date of retirement; *or*
  - Former legislators who served in the New Mexico State Legislature for at least two years are also eligible.

- You served as a non-salaried member of the governing authority of an employer eligible group to participate in the benefits of the Retiree Health Care Authority Act. An example is a former school board member.

Eligible Dependent

An *eligible Dependent* is a person obtaining NMRHCA health care coverage based upon that person's relationship to an eligible retiree. Eligible Dependents include the following:

- A spouse
- A domestic partner
- An unmarried, Dependent child under the age of 26, including:
  - A natural child
  - A legally adopted child
  - A stepchild living in the same household who is primarily dependent on the eligible retiree for maintenance and support
  - A child for whom the eligible retiree is the legal guardian and who is primarily Dependent on the eligible retiree for maintenance and support, as long as evidence of the guardianship is provided in a court order or decree
  - A foster child living in the same household as the eligible retiree
  - A Dependent child over age 26 who is wholly dependent on the eligible retiree for maintenance and support and incapable of self-sustaining employment by reason of mental retardation or physical handicap. Proof of incapacity and dependency must be provided within 31 days after the child reaches the limiting age and such times thereafter, as may be required by NMRHCA. The disability must have occurred before the limiting age.
- A surviving spouse (the spouse to whom a deceased eligible retiree/vested-active employee and/or participant was married at the time of death) *or* a surviving Dependent child of a deceased eligible retiree/vested-active participant, whose other parent is also deceased.

Right of Survivorship

An eligible Dependent of a deceased eligible retiree/vested-active Member may be covered under the same terms and conditions as would apply if the retiree were still living, except that the Dependent is not entitled to carry retiree life insurance. The surviving Dependent is enrolled (or re-enrolled) under his/her own Social Security Number and is assessed the applicable spouse or Dependent rate for medical plan premium contributions. This is called "right of survivorship," and it will continue to be offered to the eligible spouse until his/her death or to the eligible Dependent child until his/her death, marriage, or ineligibility. Dependents of the surviving spouse or child are not eligible for this program unless they are related to the deceased retiree as described under "Eligible Dependents," earlier in this section. For example, if a surviving spouse remarries, his/her new spouse is not eligible for this program.

A child is considered to be a specific age on the first day of the month following his/her birthday. **Proof of incapacity** and dependency must be furnished periodically by you to NMRHCA.

Your spouse or children are not eligible while:

- On active duty in the armed forces of any country; or
- Covered under this program as a retiree or a Dependent of another retiree.

It is your responsibility to notify NMRHCA (who will then notify Presbyterian Health Plan) of any change in your coverage status, including a name or address change, or an addition or removal of a Dependent (spouse or child). If you have questions about a Dependent's eligibility, contact NMRHCA at 1-800-233-2576 for details and forms.

Adding Dependents

You may apply for coverage of your eligible dependents.

For dependents who are newly eligible due to an event such as marriage, or birth you need to apply for dependent coverage before or **within 31 days** of the event. If you do not apply within the 31 days, your Application for the additional dependent(s) will be denied. (See "Late Applicants" earlier in this section.)

Exception: When an eligible retiree, spouse, or dependent was receiving group health coverage through a third party and involuntarily loses the coverage due to a change in eligibility status, the eligible retiree, spouse, or dependent will be considered to have experienced a qualifying event under Section 125 of the Internal Revenue Service Code. In such cases, if the loss of coverage was not caused by any neglect or wrongdoing by the eligible retiree, spouse, or dependent, he/she may enroll **within 31 days** of the change of status without being considered a late applicant.

Removing Dependents

When a dependent becomes ineligible through death, divorce, annulment, or legal separation, coverage ceases at the end of the month that caused the dependent to lose eligibility. If a dependent becomes ineligible, coverage ceases at the end of the month. The retiree is responsible for submitting a Change of Enrollment form to remove the dependent from coverage. Contact NMRHCA at 1-800-233-2576 for the necessary form.

How Coverage Stops

Coverage under NMRHCA Plan terminates when:

1. The retiree or dependent ceases to be eligible;
2. NMRHCA ceases to provide health care benefits;
3. The retiree or surviving dependent fails to make any required premium payment for coverage when due;
4. The retiree or dependent commits fraud or material misrepresentation affecting coverage;
5. There is a material failure by the retiree or dependent to abide by the rules and/or policies and procedures of NMRHCA Plan;
6. The retiree requests cancellation of any or all Plans (the effective date of cancellation will depend on the date NMRHCA receives the written request);

7. The retiree dies (right of survivorship will continue to be offered to the retiree's eligible spouse until his/her death, and to the retiree's eligible dependents until their death, marriage, or ineligibility).

A Member is required to **switch** from this non-Medicare Plan to a Medicare-secondary plan when he/she becomes eligible for Medicare. Contact NMRHCA at 1-800-233-2576 for more information.

How Coverage May Continue

If a Member loses coverage under this Plan, there are a number of ways that health care coverage can be continued:

Continuation of Coverage

The COBRA law allows the continuation of health care coverage for a retiree and/or his/her Dependents when they are no longer eligible for these reasons:

- The retiree's spouse ceases to be an eligible dependent as a result of divorce or legal separation; or
- The retiree's dependent child ceases to be an eligible dependent; or
- The retiree ceases to receive a pension.

To obtain this continuous coverage, the person who wants to continue coverage must submit written notice to NMRHCA **within 60 days** after the event that caused the ineligibility. NMRHCA will give a written election notice of the right to continue the coverage. If the person wants to continue the coverage, this notice must be completed and returned to NMRHCA **within 60 days** of the latter of:

- The date the coverage would otherwise have ended; or
- The date of the notice informing the person of the right to continue; but in no event may election be made more than 120 days after the retiree's death (150 days after the dependent's ineligibility date).

The first payment for the continued coverage must be made by the **45th day** after the date the election notice is completed. If this is done, the coverage will be continued until the first of these dates:

- 36 months from the earliest of the following events:
  - Retiree's death; or
  - Retiree's divorce or legal separation from his/her spouse; or
  - The retiree's dependent child ceasing to be an eligible dependent as specified by NMRHCA state law.
- If the person fails to make any payment required by NMRHCA for the continued coverage, the end of the period for which the person has made the required payments.
- The day the person becomes covered under any other health plan for persons in a group, on an insured or uninsured basis. However, coverage is not prevented from being continued until the end of any period under the other health plan for which pre-existing conditions are excluded and benefits for them are limited.
- The day the person becomes entitled to Medicare benefits.
- NMRHCA Plan providing the coverage ends.

For this continuation of coverage provision, all other terms of the Plan will apply, except that unearned premiums will be paid to that person's estate. When the person who elected the continuation right dies, and the person was:

- The retiree's spouse, benefits will be paid to:
  - The spouse's estate, if the spouse survived his/her dependent children; or
  - The person or institution appearing to the Claims Administration to have assumed the main support of the eligible dependent children, if the spouse did not survive his/her dependent children.
- The retiree's dependent child, benefits will be paid to the child's estate.

Medicare

Within three months before you or your spouse becomes age 65, or if you or a covered dependent qualifies for Medicare benefits for any other reason, contact the local Social Security office to establish Medicare eligibility. NMRHCA will send you information about your coverage options three months before the month in which you turn 65. Members, who are eligible for both parts of Medicare, whether or not they choose to enroll, can be covered under one of the Medicare-primary plans; they are not eligible for this Plan.

Note:
Members who are not eligible for premium-free Medicare Part A should apply for Medicare Part B. Although Medicare allows you to reject Medicare Part B, you are strongly encouraged to purchase it; otherwise, you will have to pay the portion of your claims that would have been covered by Medicare Part B.

For participants who are not enrolled in Medicare Part B, benefit payments will be calculated as if Medicare had paid 80 percent of the billed charge for a Covered Service (this amount is the Member's responsibility and does **not** accrue to the Out-of-Pocket Maximums). Benefit payments will be either:

- The remaining 20 percent of the billed charge for a Covered Service, or
- The amount the Plan would have paid as primary payer (based on the Presbyterian Health Plan maximum allowable fee)–whichever is less.

ID Card

Your Plan ID Card identifies the cardholder and your PPO 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 preadmission review or other prior approvals. You are responsible for any Copayments, Coinsurance, or expenses for non-Covered services.

On your card are your Member identification number and your group number. The reverse side of your ID Card provides the address for Presbyterian Health Plan and some important telephone numbers for your use while using the Plan. It is important that you always show the individual's own ID Card when obtaining care.

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

If you want additional cards or need to replace a lost card, contact the Presbyterian Customer Service Center, Monday through Friday, between 7 a.m. and 6 p.m. at (505) 923-5600 (in Albuquerque), or toll free at 1-888-275-7737 (Ask-PRES). TTY users may call 1-877-298-7407.

This card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits.

COVERED SERVICES

Benefits are subject to the Copayments and Coinsurance listed in the *Schedule 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 Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures" in Section 6.

ACCIDENTAL INJURY/MEDICAL EMERGENCY CARE/URGENT CARE

Medical Emergency Care

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

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

No notification or **Prior Authorization** is required for Out-of-network (including out-of-state) Hospitals or treatment facilities for Medical Emergency services. Physician and other professional provider care received during the visit are subject to deductible and coinsurance, in addition to the Copayment listed for the facility 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 judgment of the Attending Physician in consultation with Presbyterian Health Plan. Presbyterian Health Plan may request that the Member be transferred to a Hospital participating in its network, if the patient is stabilized and the transfer completed in accordance with federal law.

If your emergency treatment requires direct Admission to the Hospital, you are responsible for the Deductible, Hospital Coinsurance and Copayment. However, the Copayment and/or Coinsurance for the Emergency Room are waived.

Urgent Care

Urgent Care means Medically Necessary Health Care Services provided in emergencies, or after normal business hours for unforeseen conditions due to illness or injury that are not life threatening, but require prompt medical attention. Examples of Urgent Care situations include, but are not limited to, sprains, high fever, minor cuts requiring stitches, and significant vomiting or diarrhea.

The Plan will reimburse for all Covered 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 may contact Presbyterian Health Plan Customer Services Center for information regarding the closest In-network Provider facility that can provide Urgent Care.

For Urgent Care received by out-of-state, no notification is required. The Member will be responsible for charges **not Covered** by the Plan.

ACUPUNCTURE SERVICES

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

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

AMBULANCE SERVICES

Benefits are available for professional Ambulance Services if they are Medically Necessary to protect the life of the patient, 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.

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

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 Presbyterian Health Plan with notice of when the Member enters and leaves a qualified clinical trial.

Routine patient care costs are Covered for Members in a Cancer Clinical Trial if:

- The Cancer Clinical Trial is undertaken for the purposes of the **prevention of or** the prevention of reoccurrence, early detection, or treatment of cancer for which no equally or more effective standard cancer treatment exists.
- The Cancer Clinical Trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.
- The Cancer Clinical Trial is being provided **in New Mexico** as part of a scientific study of a new therapy or intervention.
- There is not a non-Investigational treatment equivalent to the Cancer Clinical Trial.
- There is a reasonable expectation shown in clinical or pre-clinical data that the Cancer Clinical Trial will be at least as efficacious as any non-Investigational alternative.
- There is a reasonable expectation based on clinical data that the medical treatment provided in the Cancer Clinical Trial will be at least as effective as any other medical treatment.
- Pursuant to the patient informed consent, Presbyterian is not liable for damages associated with the treatment provided during any phase of a Cancer Clinical Trail.

These services require **Prior Authorization** from Presbyterian Health Plan. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorization** with your Physician before obtaining services

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

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, the cost of equipment rentals and supplies; and
- Treatment of disease by x-ray, radium, or radioactive isotopes.

CHIROPRACTIC SERVICES

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

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

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.

To be Covered, *initial* treatment for the injury must be sought within **72 hours** of the accident. Any services required after the initial treatment must be received **within 12 months** of the date of accident in order to be Covered. Dental prostheses may include the placement of dental implants to restore the area of trauma only if it is determined to be the most cost effective restoration to normal form and function.

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

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

Pediatric anesthesia in a day surgical unit may be a Covered Service for pediatric dental procedures if found to be Medically Necessary. The dental procedure itself is **not a Covered Service** unless conditions for trauma or oral Surgery are met.

Oral Surgery and Temporomandibular Joint 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;
- Removal of teeth required due to a side effect from radiation or chemotherapy treatment, before radiation therapy of a cancerous area, or Medically Necessary due to damage from medical treatment (such as prolonged, Medically Necessary use of certain oral medications);
- 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 Temporomandibular Joint Surgery; and
- Frenectomy.

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

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

DIABETES EDUCATION

Diabetes education is a Covered Service and 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 health care Provider with prescribing authority.

DIABETES SUPPLIES AND SERVICES

When prescribed by the Member's Physician (also see the Express Scripts Benefits brochure or call them at 1-800-501-0987) the following equipment, supplies, appliances, and services are Covered for Members with diabetes:

- Standard blood glucose monitors;
- Specialized blood glucose monitors (including those for the legally blind);
- Test strips for blood glucose monitors;
- Visual reading urine and ketone strips;
- Lancets and lancet devices;
- Insulin;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Syringes;
- Glucagon emergency kits;
- 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 Presbyterian Health Plan; and
- Insulin pumps when Medically Necessary, prescribed by a licensed endocrinologist.

In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization,** when required. Discuss the need for **Prior Authorization** 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.

Note:
The above items are also available through your Prescription Drug Coverage. Contact Express Scripts at 1-800-501-0987 for more information, if you purchase your diabetic supplies through a pharmacy.

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

- Insulin pumps if Medically Necessary;
- 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;
- Glucagon emergency kits; and
- Blood glucose monitors, including those for the legally blind.

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 karyo typing and molecular cytogenetic testing;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Magnetic Resonance Imaging (MRI) - may require Prior Authorization;
- Computed Axial Tomography (CAT/CT) - may require Prior Authorization;;
- Positron Emissions Tomography (PET) - may require Prior Authorization;
- Sleep disorders; 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 Presbyterian Health Plan, 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 ankle foot orthoses and/or knee-ankle-foot orthoses (AFO and/or KAFO).
- 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 are considered deluxe, and therefore, are **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 (not subject to deductible and/or coinsurance) –
  - Hearing aids and the evaluation for the fitting of hearing aids are Covered for school aged children under 18 years old (or under 21 years of age if still attending high school) up to $2,200 every 36 months "per hearing impaired ear". This coverage includes fitting and dispensing services (and ear molds) as necessary to maintain optimal fit.
  - Benefits are limited for all other members to a maximum of $500 in benefit payments during any three-year period. This benefit does not include coverage for a hearing test or any charge related to the fitting or prescribing of the hearing aid. The three-year period is not based on a calendar year. The three-year period begins on the date you purchase your first hearing aid and ends three years later. This benefit does include repair and replacement of hearing aids. Note: This benefit is available only to those who are not eligible for the "school aged" benefit listed in the previous paragraph;
- 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 Presbyterian Health Plan prior to services being rendered.

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 two 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.);

- Other supplies determined by Presbyterian Health Plan to be Medically Necessary and covered under the Plan.

Prior Authorization from Presbyterian Health Plan is required for the following:

- **Durable Medical Equipment, medical supplies (including enteral feeding tubes), orthopedics appliances, orthotics, and surgically implanted prosthetics; and**
- **Any item costing $500 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.).**
- **In Network Providers request Prior Authorization for you. If you access care from an Out-of-network Provider, you will have to obtain Prior Authorization. Failure to do so may result in benefits being reduced or denied.**

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

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

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

FAMILY PLANNING AND RELATED SERVICES

Family planning services are Covered for the following procedures:

- Injection of Depo-Provera for birth control purposes;
- Diaphragm, including fitting;

- 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 done during a delivery, only the Maternity Copayment applies. There will not be an additional Surgery Copayment); and
- RU486 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(s) being replaced.

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

This Plan does **not Cover** any services or charges for artificial conception including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as artificial insemination, in-vitro ("test tube") or in-vivo fertilization, Gamete Intrafallopian Transfer/Zygote Intrafallopian Transfert (GIFT, ZIFT), all drugs, hormonal manipulation, or embryo transfer is not a Covered Service. 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 Member Benefit Booklet. Medical services provided by licensed healthcare 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;

- Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status when Prior Authorization is obtained from Presbyterian Health Plan's pharmacy department.

Special Medical Foods are Covered when prescribed by a Physician for treatment of Genetic Errors of Metabolism, and the Member is under the Physician's ongoing care. Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.
For prescription drug and special medical foods coverage, contact Express Scripts.

Exclusions:
- Food substitutes for lactose intolerance including soy foods or formulas or other over the counter digestive aids,
- Organic foods,
- Ordinary foodstuffs that might be part of an exclusionary diet,
- Food substitutes that do not qualify as Special Medical Foods,
- Any product that does not require a Physician's prescription,
- Special Medical Foods for conditions that are not present at birth,
- Food items purchased at a health food, vitamin or similar store,
- Foods purchased on the Internet, and
- Special Medical Foods for conditions including, but not limited to: diabetes mellitus, hypertension, hyperlipidemia, obesity, and allergies to food products.

Please refer to your *Schedule of Benefits* for applicable office visit, inpatient Hospital, outpatient facility, prescription drug and other related Copayments.

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. This benefit conserves Hospital beds for acutely ill patients and reduces the cost of health care.

Before the Member receives home health care, the treating Physician or Home Health Agency must request **Prior Authorization** from Presbyterian Health Plan. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorization** with your 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** in writing from Presbyterian Health Plan. **Prior Authorization** requires a written treatment program approved by the treating Physician. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for a written **Prior Authorization** 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.

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 Presbyterian Health Plan. No more than one additional Hospice benefit will be approved.

Benefits are available ***only*** for or on behalf of an approved Hospice agency. An approved Hospice agency must be:
- Licensed when required;
- Medicare-certified as a Hospice agency; or
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Hospice agency.

The following services ***are Covered*** under this Hospice benefit:
- Inpatient Hospice care;
- Hospice care 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, 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 *Member Benefit Booklet*, subject to applicable Copayment, and Coinsurance 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. **Prior Authorization** is required from Presbyterian Health Plan prior to being admitted (unless it is an emergency). In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**.

Benefits are available for a non-private room with two or more beds. Private room charges are a Covered Benefit only when Medically Necessary, when the private room is ordered by the Member's admitting Physician, and **Prior Authorization** is obtained from Presbyterian Health Plan. If the Member requests a private room or the private room is not Medically Necessary, Presbyterian Health Plan bases payment on the Hospital's average non-private room rate and the Member is responsible for the balance. The balance you pay does not apply to the Out-of-Pocket Maximum.

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

- Sub-Intensive Care Unit; and
- Isolation Room.

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 Presbyterian Health Plan 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.

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.

MASSAGE THERAPY

Only services administered by a Licensed Massage Therapist, licensed Physical Therapist, a medical doctor, a Doctor of Osteopathy, a Doctor of Oriental Medicine, or a Chiropractor operating under the scope of their license on an Outpatient basis are a Covered Service if necessary for treatment of an illness or Accidental Injury. *No* benefits are paid for Maintenance Therapy.

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

MATERNITY AND NEWBORN CARE

Benefits include complete prenatal care, pregnancy related diagnostic tests, prescription drugs, visits to an obstetrician, Certified Nurse-Midwife, or licensed midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse-Midwife or Physician. Benefits are available for delivery at home by a Certified Nurse-Midwife or a licensed midwife. Lay midwife deliveries are **not a Covered** Service.

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.

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. No pre-existing condition limitation applies.

However, if you do not apply for your newborn child within 31 days of birth, you must wait until the next open or switch enrollment under the late applicant provisions. No pre-existing condition limitation applies.

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

A separate Deductible and Inpatient Copay applies for your newborn 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 Deductible/Copay 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, you must notify Presbyterian Health Plan Health Services by calling toll free 1-800-923-5757 before the mother is discharged from the Hospital to coordinate the baby's care. The baby's services will be subject to a separate deductible, coinsurance, copay and out-of-pocket limit.

Newborns and Mothers Health Protection Act
Under Federal law, group health plans and health insurance issuers offering group insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. You need not obtain authorization from Presbyterian Health Plan for a length of stay not in excess of the above periods.

BEHAVIORAL HEALTH AND ALCOHOLISM AND/OR SUBSTANCE ABUSE

To obtain benefits for Outpatient services related to Behavioral Health and Alcoholism and/or Substance Abuse, it is not necessary to obtain a referral. You must call the Presbyterian Health Plan Behavioral Health Department directly at (505) 923-5470 or toll-free 1-800-453-4347.

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

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 Behavioral 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.

Behavioral Health Services

Inpatient behavioral health services will be Covered when performed by a licensed Provider. All Inpatient services require Prior Authorization by Presbyterian Health Plan's Behavioral Health Department. Please call 1-800-453-4347 and ask for the Behavioral Health Department.

Partial Hospitalization can be substituted for the Inpatient behavioral health services. Partial hospitalization is a non-residential Hospital-based day program attended by the Member at least three 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 Presbyterian Health Plan's Behavioral Health Department. Failure to obtain **Prior Authorization** for services will result in no benefit coverage.

Outpatient, non-Hospital based, short-term evaluative and therapeutic behavioral health services will be provided based on Medical Necessity.

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

Outpatient services also include treatment, to include individual, group or family counseling, medication management and neuropsychological testing for behavioral health and/or substance abuse for most behavioral health diagnoses. In addition, therapies for marriage, family and relationship problems, physical and/or sexual abuse, and problems related to a behavioral disorder or medical condition are also Covered.

Alcoholism and/or Substance Abuse Services

Benefits for Alcoholism and or Substance Abuse are limited to the number of days listed in the *Schedule of Benefits*. All Inpatient services and some outpatient services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department; failure to do so will result in benefits being denied.

Inpatient treatment in a Hospital or Substance Abuse treatment center requires **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department. Coverage will be provided up to the number of days listed in the *Schedule of Benefits* per Member per Calendar Year. Failure to obtain **Prior Authorization** for services will result in denial of coverage. Please refer to the *Schedule of Benefits* for day limitations.

Partial Hospitalization can be substituted for Inpatient Alcoholism and/or Substance Abuse services. Partial hospitalization is a non-residential day program, attended by the Member at least three hours a day, but not more than 12 hours in any 24-hour period, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Partial hospitalization services requires **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department. Failure to obtain **Prior Authorization** for services will result in no benefit coverage. Please refer to the *Schedule of Benefits* for day limitations.

Outpatient, non-Hospital based, intensive and standard Outpatient evaluative and therapeutic services for Alcoholism and/or Substance Abuse will be provided. Some outpatient services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department; failure to do so will result in benefits being denied.

The combined coverage for all Outpatient evaluative and therapeutic Alcoholism and/or Substance Abuse services (both intensive and standard) is **limited** to the number of visits per Member per Calendar Year listed in the *Schedule of Benefits*. Intensive Outpatient Alcoholism and/or Substance Abuse services are defined as visits lasting up to nine hours per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting between 15 and 110 minutes**.**

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

Outpatient services also include treatment, to include individual, group or family counseling, medication management and neuropsychological testing for Behavioral Health and/or Substance Abuse for most behavioral health diagnosis. In addition, therapies for marriage, family and relationship problems, physical and/or sexual abuse, and problems related to a behavioral disorder or medical condition are also Covered.

PHYSICIAN SERVICES

Please refer to the *Schedule of Benefits* for applicable Copayments/Coinsurance for the following services.

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

Chronic Pain Treatment
Chronic pain treatment is a benefit when used for palliative care administered by a Physician only.

Contraceptive Devices
Benefits are available for contraceptive devices that require a prescription by a Physician including:

- IUDs; and
- Diaphragms.

If you must obtain the IUD or diaphragm, you will have to pay for the item and then file a claim to Presbyterian Health Plan. All other contraceptive devices that do not require a prescription are not a benefit. For oral contraceptive prescription drug benefits, see the Express Scripts benefits booklet or call them at 1-800-501-0987.

Injectable Drugs
U.S. Food and Drug Administration (FDA) approved therapeutic injections administered in a Provider's office are Covered. However, certain injectable drugs (such as growth hormone and interferon alfa-2) are Covered only when **Prior Authorization** is received from Presbyterian Health Plan. Your Presbyterian Health Plan In-network Provider has a list of those injectable drugs (over $100) that require **Prior Authorization**. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. If you need a copy of the list, contact a Presbyterian Customer Service Center representative.

Presbyterian Health Plan reserves the right to exclude any injectable drug currently being used by a Member that is not specifically listed as Covered. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a Presbyterian Health Plan 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.

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

Weight Management and Nutritional Counseling
Weight loss management, obesity treatment, and nutritional counseling are not benefits unless dietary advice and exercise are provided by a Physician, licensed nutritionist, or registered dietitian. Weight loss management, obesity treatment, and nutritional counseling must be prescribed by a licensed Physician and are a benefit only when Medically Necessary and for a body mass index (BMI - weight in kilograms divided by height in meters squared) of 40 or more. Weight loss medications require Pre-Approval by Express Scripts, the company that supplies pharmacy services for NMRHCA Members. Express Scripts can be reached at 1-800-501-0987. Also, see Morbid Obesity.

PREVENTIVE SERVICES

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

Benefit payments for services listed in this section are not subject to Copayments for care received by an In-network Provider. However, the applicable Coinsurance does apply for services listed in this section when provided by an Out-of-network Provider (Deductible is waived). Please see the *Schedule of Benefits* for Coinsurance amounts.

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

Cytologic Screening (Pap smear screening)
Benefits are available to determine the presence of precancerous or cancerous conditions and other health problems in accordance with the national medical standards for women who are 18 years of

age or older and for women who are at risk for cancer or at risk for other health conditions that can be identified through cytological screening.

Health Education and Counseling

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

- If you are 20 years of age or older, you may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. Included in the consultation may be, but not limited to:
  - Smoking control;
  - Nutrition and diet recommendations;
  - Exercise plans;
  - Lower back protection;
  - Immunization practices;
  - Breast self-examination;
  - Testicular self-examination;
  - Use of seat-belts in motor vehicles; and
  - Other preventive health care practices.

- If you are under age 20, educational materials or consultation to discuss lifestyle behaviors that promote health and well-being including, but not limited to:
  - The consequences of tobacco use;
  - Nutrition and diet recommendations;
  - Exercise plans; 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.

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

Mammography Coverage

Benefits are available for low-dose screening mammograms for determining the presence of breast cancer. Guidelines for routine mammography are:

- A baseline before age 40;
- One every 1-2 years for ages 40 and over; and
- As otherwise medically indicated.

Prostate Exams

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

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

Routine Eye Examinations

Routine eye exams are provided only by licensed Providers to determine the need for vision correction are a Covered Service and are limited to screening only for Members through age 17. This does not include routine eye exams or refractions performed by eye care specialists.

Routine Hearing Screening

Routine hearing screening performed only by licensed Providers to determine the need for hearing correction are a Covered Service and are limited to screening only for Members up through and including age 17 (and for those age 18 to 21 if they are still in high school).

Routine Immunizations

Routine immunizations are not subject to Copayments when provided by an In-network Provider, to include flu shots and other Covered adult immunizations including pneumococcal vaccine, diphtheria/tetanus, meningitis, and hepatitis when clinically appropriate as determined by Presbyterian Health Plan. If these same services are obtained from an Out-of-network Provider, the applicable Coinsurance will apply (Deductible is waived). (Please see the *Schedule of Benefits*.) Immunizations for employment and travel are not a Covered benefit.

Routine Physical Examinations

This benefit is not subject to an office visit Copayment for service provided by an In-network Provider. However, the applicable Coinsurance does apply for services provided by an Out-of-network Provider (Deductible is waived). It provides coverage for routine physical, breast, gynecological and pelvic examinations as well as periodic tests to determine blood hemoglobin, blood pressure and blood glucose level.

The following is a suggested schedule for routine physical examinations, after an initial examination:

- Ages 8-19, see Well Child Care (next page);
- Ages 20-39, an exam every five years;
- Ages 40-49, an exam every three years; and
- Ages 50 and over, an exam every two years.

Additional 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 40 or older;
- Periodic left-sided colon examination of 35 to 60 centimeters for Members age 45 or older; and
- Periodic glaucoma eye tests for Members age 35 or older.

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

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

Well-Child Care

Well-child Care is a Covered Service including diagnosis or treatment of injury. 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 three through 18.

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. This benefit is limited as shown in the *Schedule of Benefits*. The Inpatient Coinsurance/Copay 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. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization,** when required. 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 *Schedule 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, and includes 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. The 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.

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. Replacement due to wear, loss or damage is **not a Covered Service**.

Cochlear Implants

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

Congenital Anomalies

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

Morbid Obesity

Benefits are available for surgical treatment of morbid obesity (bariatric surgery) **only** when prescribed by a Physician, when Medically Necessary, and with a body mass index (BMI - weight in kilograms divided by height in meters squared) of 40 or more. Prior Authorization may be required from Presbyterian Health Plan prior to services being rendered. If you access care through an In-Network Provider, they will obtain **Prior Authorization,** when necessary. If you access care from Out-of-network Provider, you will have to **obtain Prior Authorization.** Failure to do so may result in benefits being reduced or denied. Also see Weight Management.

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

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

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

Reconstructive Surgery that is required 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. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**.

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

When breast reconstruction is chosen, Covered Services include:
- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetry between the two breasts, including nipple reconstruction; and
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas as determined by the Attending 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 Service when deemed Medically Necessary. Replacement of the Prosthesis is **not** a Covered Service 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.

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

NOTE: If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedure" in Section 6.

THERAPY

Physical, Occupational, and Speech Therapy

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

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

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

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.

Pre-screening at the time of the transplant evaluation and services necessary to complete the evaluation are included in the lifetime benefit maximum as shown in the *Schedule of Benefits*.

Organ transplant services include the recipient's medical, surgical and Hospital services; Inpatient Immunosuppressive medications; and costs for organ procurement. Transplant services are Covered only if they are required to perform any of the following human to human organ or tissue transplants: cornea, heart, heart, kidney/pancreas, kidney, liver, lung, pancreas, intestine, or small bowel/liver. Also Covered are islet cell infusion and autologous or allogeneic bone marrow transplants, including peripheral stem cell, as determined to be Medically Necessary.

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

The treating Physician must obtain **Prior Authorization** from Presbyterian Health Plan before benefits for any transplant procedure is provided. **Prior Authorization**, requested in writing, must be obtained from Presbyterian Health Plan before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is **not Covered** if **Prior Authorization** is not obtained from Presbyterian Health Plan. A Presbyterian Health Plan case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation. Transplant services are **not Covered** when provided by an Out-of-network Provider. 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 Presbyterian Health Plan. Call Presbyterian Health Plan toll free at 1-800-453-4347 for a current list of Presbyterian Health Plan 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 Presbyterian Health Plan case manager), Surgery, organ storage expenses, and Inpatient follow-up care only. Donor organ procurement costs are subject to the maximum lifetime payment as shown in the *Schedule of Benefits*.

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, Coinsurance and Out-of-Pocket Maximum; annual home health care maximums).

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

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 Presbyterian Health Plan approved Organ Transplant facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include the following charges:

- 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. For a transplant patient 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 companions. All benefits for transportation, lodging, and meals are limited to a maximum payment of $10,000 and are included in the maximum lifetime benefit shown in the *Schedule of Benefits*. Travel expenses are **not** Covered and per diem allowances are **not** paid if the travel occurs more than five days before or more than one year following the actual transplant.

Total benefits for transplant, services, and supplies provided after the transplant are limited to a lifetime maximum payment (excluding drugs for use while at home) per Member as shown in the *Schedule of Benefits*. Benefits applied toward this maximum include payments for hospitalization and all allowable expenses for one or more transplants, and for any subsequent hospitalizations and medical services related to the transplant.

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 *Member Benefit Booklet*. Follow-up care and complications of non-covered transplants are not a Covered Service.

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

Note:
If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedure" in Section 6.

WIG/HAIRPIECE

This Plan Covers a wig or hairpiece (synthetic, human hair, or blends) **only** when prescribed by a Physician for hair loss due to injury, disease, or treatment of the following:

- Alopecia areata with near complete or complete cranial hair loss;
- Alopecia totalis;
- Alopecia universalis;
- Burns – 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia;
- Chemotherapy
- Fungal infections not responsible to an appropriate (typically 6 week) course of antifungal treatment resulting in near complete or complete cranial hair loss;
- Lupus; and
- Radiation Therapy.

Coverage is limited to a maximum of $200 every three years. Annual Deductible and Coinsurance applies. **Prior Authorization** by Presbyterian Health Plan is required. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization,** when required. Discuss the need for **Prior Authorization** with your Physician before obtaining services.

This Plan does **not Cover** wigs/hairpieces for androgenetic alopecia (also known as male patterned baldness).

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 Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedure" in Section 6.

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, massage therapy, and Rolfing.

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, tension headaches, migraines, Craniomandibular Joint and Temporomandibular Joint (CMJ/TMJ) disorders.

Chiropractic (manipulations) services are limited to a Calendar Year maximum benefit of $1,500 per Member for Covered expenses, in combination with services provided for Acupuncture, massage therapy, and Rolfing.

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. Presbyterian Health Plan **does not Cover** supplies used at other times by the Member or Member's family. Consumable medical supplies are (1) usually disposable, (2) cannot be used repeatedly by more than one individual, (3) are primarily used for a medical purpose, (4) generally are useful only to a person who is ill or injured and (5) are ordered or prescribed by a licensed Provider.

Contact lenses or eyeglasses (one set) are limited to services necessary to replace lenses absent at birth, lost through cataract or other intraocular Surgery, or prescribed by a Physician as the only treatment available for keratoconus.

Dental prostheses, craniomandibular joint (CMJ) and temporomandibular joint (TMJ) disorders, pediatric anesthesia and oral surgery benefits require **Prior Authorization** or no benefits may be payable through the Plan. Also, this Plan Covers only those procedures listed as covered benefits. This Plan does **not Cover** any other oral or dental procedures such as, but not limited to the following:

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

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

Family planning coverage is limited to Depo-Provera injections, diaphragms, intrauterine devices (IUDs), genetic testing and sterilization procedures.

Hearing Aids are Covered, but the coverage is limited as follows:

- Hearing aids and the evaluation for the fitting of hearing aids are Covered except for school aged children under 18 years old (or under 21 years of age if still attending high school) up to $2,200 every 36 months "per hearing impaired ear". This coverage includes fitting and dispensing services (and ear molds) as necessary to maintain optimal fit.
- Benefits are limited for all other member to a maximum of $500 in benefit payments during any three-year period. This benefit does not include coverage for a hearing test or any charge related to the fitting or prescribing of the hearing aid. The three-year period is not based on a calendar year. The three-year period begins on the date you purchase your first hearing aid and ends three years later. This benefit does include repair and replacement of hearing aids. Note: This benefit is also limited to those who are not eligible for the "school aged" benefit listed in the previous paragraph.

Home health care services require **Prior Authorization**. Discuss the need for **Prior Authorization** with your Physician.

Hospice care benefits are limited to patients who are terminally ill as described in Section 4. Written **Prior Authorization** is required from Presbyterian Health Plan. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization.** Discuss the need for **Prior Authorization** with your Physician.

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

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

Massage therapy is limited to a Calendar Year maximum benefit of $1,500 per Member for Covered Services, in combination with services provided for Acupuncture, chiropractic services, and Rolfing. In addition, in order for services to be Covered under this Plan, services must be provided by a Physical Therapist, medical doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or a Chiropractor.

Preventive Services are limited to schedules as detailed in Section 4.

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

Repair or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the member's condition, or after the product's normal life expectancy has been reached and when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being rendered.

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

Routine eye examinations are limited to children through age 17.

Routine hearing screenings are limited to children up through and including age 17 (and for those age 18 to 21 if they are still in high school).

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

Skilled nursing care is limited to 60 days of services per Calendar Year and is subject to **Prior Authorization** by Presbyterian Health Plan. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorizations** with your Physician.

Substance Abuse benefits are **limited** as follows: Services for any combination of Inpatient, partial, and Outpatient benefits are limited to 30 visits per Calendar Year and two courses of treatment per lifetime for substance abuse services. All Inpatient services require Prior Authorization to be considered an eligible expense under this Plan.

Transplants: Benefits for travel, lodging, and meals are limited to an adult transplant recipient and one other person. For minor children, benefits are payable for two adults. 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 charges.

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

EXCLUSIONS

Any service, supply, item, or treatment not listed as a Covered Service in Sections 4 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 Service, 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 Service.

Ambulance (including air ambulance) charges that are not Medically Necessary.

Amniocentesis and/or ultrasound to determine the gender of a fetus are **not Covered Service**s 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 Service under this Plan.

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

Behavioral disorders are not a Covered Service under this Plan unless associated with a manifest behavioral disorder.

Behavioral 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 behavioral illness or other disturbances; and
- Non-national standard therapies, including Experimental as determined by the behavioral health professional practice.

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, except in an emergency.
- Made by a family Member (spouse, parent, grandparent, sibling or child) or someone who lives with you.

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

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

Contact lenses or eyeglasses unless specifically listed as a Covered Service under this Plan.

Convalescent care or rest cures.

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

Counseling services are not a Covered Service under this Plan unless listed as a Covered Service.

Court ordered services are not a Covered Service 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 to include periodontal Surgery except if the services required are due to Accidental Injury of sound natural teeth or as otherwise listed as a Covered Service under this Plan.

Dental implants are not Covered.

Dependent of a Dependent (grandchild) expenses are not a Covered Service 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 Service under this Plan, except as specified in this *Member Benefit Booklet*.

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

Duplicate diagnostic 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 Service under this Plan.

Exercise equipment is not a Covered Service under this Plan.

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

- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvements must be attainable outside the Investigational settings.

Eye exercises and refractions are not a Covered Service 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.

Hearing exams and procedures: This Plan does **not Cover** audiometric (hearing) tests unless
- Required for the diagnosis and/or treatment of an illness or Accidental Injury;
- Covered as a preventive screening service for children through age 18 as part of a routine physical exam; or
- Covered as outlined in Section 4 under "Hearing Aids".

For surgically implanted devices, see "Surgery" in Section 4.

Genetic Inborn Errors of Metabolism (IEM):
- Food substitutes for lactose intolerance including soy foods or formulas or other over the counter digestive aids,
- Organic foods,
- Ordinary foodstuffs that might be part of an exclusionary diet,
- Food substitutes that do not qualify as Special Medical Foods,
- Any product that does not require a Physician's prescription,
- Special Medical Foods for conditions that are not present at birth,
- Food items purchased at a health food, vitamin or similar store,
- Foods purchased on the Internet, and
- Special Medical Foods for conditions including, but not limited to: Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, and Allergies to food products.

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 *Member Benefit 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 Covered Service** 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 Service under this Plan. Also see the exclusion under Artificial conception (earlier in this section).

Implantation of artificial organs or mechanical devices, except as specified in this *Member Benefit Booklet*, are not a Covered Service under this Plan, unless as a result of illness or injury and Prior Authorization is obtained from Presbyterian Health Plan prior to services being rendered.

Late claims filing: This Plan does **not Cover** services submitted for benefit determination if Presbyterian Health Plan receives the claim **more than 12 months** after the date of service. Note: If there is a change in the Claims Administrator, 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.

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 unless performed by a Licensed Massage Therapist, Licensed Physical Therapist, a medical doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

Medical equipment to include, but not be limited to, stethoscopes and blood pressure monitors 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).

Membership fees are not a Covered Service under this Plan.

Mobile or temporary testing units who submit a bill to this Plan will have those charges denied, to include services for pap smears, 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 are **not Covered** under this Plan.

Non-medical equipment is not a Covered Service under this Plan.

Non-medical expenses: This Plan does **not Cover** non-medical expenses (even if medically recommended and regardless of therapeutic value), including charges for services such as, but not limited to: missed appointments, "get-acquainted": visits without physical assessment or Medical Care, the provision of medical information to perform preadmission 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.

Non-prescription 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 *Member Benefit Booklet*.

Non-standard or deluxe equipment is not a Covered Service under this Plan.

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

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, non-standard diagnostic, therapeutic and surgical treatments of CMJ or TMJ are not benefits under any circumstances.

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

Orthoptics are not a Covered Service 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.

Photophoresis for all conditions other than mycosis fungoides**.**

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 1-800-501-0987.

Private room expenses are not a Covered Service 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 surgeries are **not Covered Service**s under this Plan.

Reversals of surgical procedures are not a Covered Service under this Plan.

Self-help programs and therapies not specifically Covered in this *Member Benefit Booklet*, such as behavior modification; music, art, dance, recreation and Z therapy; massage therapy except when performed by a Licensed Physical Therapist, a Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

Services not specifically identified as a benefit in this *Member Benefit Booklet*, or **services not listed as a Covered Service** in this *Member Benefit Booklet*.

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

Speech therapy charges not otherwise listed as a Covered Service under this Plan.

Sperm storage is not a Covered Service under this Plan.

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

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

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

Transplants not specifically listed as a Covered Service 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 a supply 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 *Member Benefit Booklet*.

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

Vitamins, dietary/nutritional supplements, special foods, formulas, or diets are **not Covered** under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a Covered Service.

Vocational rehabilitation services are not a Covered Service 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, Covered Services.

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. (Presbyterian Health Plan 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 retiree and/or participant'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.)

FILING CLAIMS

This is a PPO-type plan wherein the In-network Providers have agreed to file your claims directly to Presbyterian Health Plan and payment is made directly to the Provider.

If you access care from an Out-of-network Provider you may have to file a claim yourself.

Out-of-network Providers

When you obtain services from Out-of-network Providers, they may file the claims with Presbyterian Health Plan. However, if the Out-of-network Providers does not file the claims, ask for an itemized statement. The Nonpreferred Provider may require you to pay these charges at the time of service.

You will be required to submit claim forms when your Nonpreferred 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.

The Member Claim Forms are available from a Presbyterian Customer Service Center representative. They can also be printed out from our website at **www.phs.org**. Please mail the claim forms and itemized bills to:

Presbyterian Health Plan
Attn: NMRHCA DSU
P.O. Box 27489
Albuquerque, NM 87125

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 Providers" 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 letterhead stationery and must show:

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

SECTION 6 - FILING CLAIMS

The only acceptable bills are those from health care 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 Presbyterian Health Plan. Please refer to the Express Scripts brochure or call them at 1-800-501-0987 for the claims filing procedures for prescription drugs.

How Payments are Made

Payments for Covered Services usually are sent directly to In-network Providers, including preferred Hospitals/treatment facilities. Payments to 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 Provider agreements and the Negotiated Fee for Service as determined by Presbyterian Health Plan. You are responsible for paying all Copayments, Coinsurance, and non-Covered Services.

If you obtain services from an Out-of-network Provider, you are responsible for any amounts greater than Reasonable and Customary amounts. You are also responsible for paying all Copayments, Coinsurance, and 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 Presbyterian Health Plan.

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

When possible, this Plan will honor an assignment of benefits; however, Presbyterian Health Plan reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits to pay anyone other than the subscriber in any circumstances.

Coordination of Benefits (COB)

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 pre-existing 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. Participant/Dependent. If the Member who received care is covered as the participant under one coverage and as a Dependent under another, the participant's coverage pay's 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 participant, 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 participant.

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

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

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

a. Court-Decreed Obligations. Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care 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 Participant. If the Member who received care is covered as an active participant under one coverage and as an inactive participant under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active participant under one coverage and as the Dependent of the *same* but *inactive* participant under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

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

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

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

Effect of Medicare Benefits

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

If you are a working Member age 65 or over and your spouse age 65 or over, you are eligible to continue the New Mexico Retiree Health Care Authority 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 a Member 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 **Presbyterian Health Plan 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.

Other valid coverage

All other insurance policies, including Medicare and other Medicare complementary or supplemental policies, both group and non-group (but **not** TriCARE, Medicaid, or Indian Health Service coverages, which are secondary to this Plan), that provide payments for medical services.

For a work-related injury or condition, see the "Work-related conditions" exclusion in Section 5. In accordance with the Retiree Health Care Act, the coverage provided by this Plan is secondary to all other valid coverage to which the eligible NMRHCA participant is entitled. NMRHCA Plan is also secondary to any NMRHCA dental or vision plan. (Contact NMRHCA at 1-800-233-2576 for coordination of benefits information for prescription drug services.) When 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.

Note: If you are eligible for Medicare Part B but have not enrolled, you will be responsible for the amount that Medicare Part B would have paid had you enrolled.

If a Member is currently covered under the continuation of coverage provision, coverage ceases at the beginning of the month in which the Member either reaches age 65 or first becomes eligible for any other valid coverage, unless a pre-existing condition limitation applies, or until the continuation of coverage period expires, whichever occurs first. If you receive more than you should have when benefits are coordinated, you are expected 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, this Plan will limit its secondary benefits payment to the difference between covered charges

for the service received and the amount that would have been paid by your other coverage. (Admission review and prior approval requirements are waived under this Plan if this Plan is secondary to other coverage.) Primary benefit reductions are not eligible for payment under this Plan.

Responsibility for Timely Notice

Presbyterian Health Plan is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this Plan, Presbyterian Health Plan has the right to pay the other plan any amount Presbyterian Health Plan determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Plan, and with that payment Presbyterian Health Plan will fully satisfy its liability under this provision.

Right of Recovery

Regardless of who was paid, whenever benefit payments made by Presbyterian Health Plan exceed the amount necessary to satisfy the intent of this provision, Presbyterian Health Plan has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

Third-Party Liability Subrogation

Third-party liability exists when someone else is or may be legally responsible for your condition or injury. When a third party is liable for the costs of any Covered Service, NMRHCA has subrogation rights. This means that NMRHCA has the right, either as co-plaintiff or by direct suit, to enforce your claim against a third party for the benefits paid to you or on your behalf. If NMRHCA provides benefits, NMRHCA has a direct first-party priority lien against any money you may recover from a third party or any other source as a result of the condition or injury. NMRHCA's lien must be satisfied regardless of the amount you recover. If a third party is or may be liable for the cost of or charges for any Covered Services, the following actions must be taken:

- You must promptly notify Presbyterian Health Plan and NMRHCA of the claim against the third party.
- If you receive money for the claim by suit, settlement, or otherwise, you or your attorney must reimburse NMRHCA for the amount of benefits provided under this Plan or an amount agreed upon with NMRHCA. You may not exclude recovery for NMRHCA health care benefits from any type of damages or settlement recovered.

You must cooperate in every way necessary to help NMRHCA enforce its subrogation rights. You may not take any action that might prejudice NMRHCA's subrogation rights. When you fail to cooperate in satisfying NMRHCA's subrogation interest and NMRHCA must file a lawsuit against you or the third party in order to enforce its rights under this provision, you or any of your Dependents receiving benefits under this Plan will be responsible for attorneys' fees and costs incurred by Presbyterian Health Plan and NMRHCA.

Subrogation

When this Plan pays for your care and you have the right to recover those expenses from the person or organization causing your illness or Accidental Injury, Presbyterian Health Plan has the right of subrogation to recover the amount it has paid. This right of subrogation against the third party may be exercised even if you do not file a legal action. The right of subrogation applies whether you recover directly from the wrongdoer or from the wrongdoer's insurer, or from your uninsured motorist insurance coverage. This applies to 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 Presbyterian Health Plan's subrogation right. You must notify Presbyterian Health Plan if you file a claim, consult an attorney, or bring action against a third party. If contacted by Presbyterian Health Plan, you must provide all requested information. Settlement of a controversy without prior notice to Presbyterian Health Plan is a breach of this agreement. In the event that you fail to cooperate with Presbyterian Health Plan or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of Presbyterian Health Plan, Presbyterian Health Plan 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 Presbyterian Health Plan 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 Presbyterian Health Plan.

GRIEVANCE PROCEDURES

Overview

Many Grievances or problems can be handled informally by calling the PHP's Consumer Assistance Office at **(505) 923-5644** or toll-free at **1-800-356-2219**. The Managed Healthcare Bureau of the New Mexico Office of Superintendent of Insurance is also available to assist you with Grievances, questions or Complaints. You may contact them toll-free at **1-855-4-ASK-OSI** (1-855-427-5674) or by mail at:

Office of Superintendent of Insurance
Managed Healthcare Bureau
Mailing Address: P.O. Box 1689, Santa Fe, NM 87504-1689
Physical Address: 1120 Paseo de Peralta, Room 428, Santa Fe, NM 87501
Main Phone: (505) 827-4601
Toll-free: 1-855-4-ASK-OSI

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

Adverse Determination Grievances: If your Grievance concerns a decision by a PHP to deny, reduce or terminate a requested healthcare service on the grounds that it is either not a Covered benefit or it is not Medically Necessary, the Grievance will be subject to the utilization management review procedure. (See "Adverse Determination Appeal Review Procedures" below.)

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

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

You may request a copy and detailed written explanation of the Grievance procedures by calling PHP at **(505) 923-5644** or toll-free at **1-800-356-2219**. Hearing impaired users may call the TTY line at **711**.

Members have 180 days from the date of the initial denial to file an appeal with Presbyterian Health Plan.

Adverse Determination Appeal Review Procedures

When you or your treating healthcare professional requests a healthcare service, PHP shall initially determine whether the requested healthcare service is Covered by your health benefits plan and is Medically Necessary within 72 hours where circumstances require expedited review and 24 working days for all other cases. If PHP's initial review results in the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the determination and of your right to request an internal review by PHP.

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

Presbyterian Health Plan
Grievance Department
9521 San Mateo NE
Albuquerque, NM 87113
(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 Office of Superintendent of Insurance at (505)-827-4601, for assistance or file a complaint electronically at https://osi.state.nm.us/consumer-assistance/forms/managed-healthcare.html.

PHP's internal Adverse Determination appeal review procedures require an initial review by a PHP medical director and then, if necessary, a second review by a medical panel. Both reviews must be completed within 72 hours when the circumstances require expedited review or within 30 calendar days of receipt of the request for internal review in all cases in which the request for review is made prior to the service requested, and does not require expedited review, and within 60 calendar days of receipt of the request in all post-service requests for internal review. If PHs medical director decides to uphold the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the medical director's decision by telephone and mail and will ask you whether you want a second review by a medical panel selected by the healthcare insurer.

If you indicate that you want a second review of your Appeal by a medical panel, then PHP will notify you of the date, time and location of the medical panel review and of your rights to participate in the review.

With each notice of a rescission of coverage or final adverse benefit determination, we will provide written notice of your right for an independent review of the determination by an IRO.

External Review by NMRHCA

If you are not satisfied with Presbyterian Health Plan's decision under either category above, you may Appeal the decision within 30 days of the day the Grievance decision was made. You may request an internal review in writing by contacting NMRHCA. Upon receipt of the formal complaint, NMRHCA will review the case and respond to the parties involved within 30 days. If the formal complaint is due to an emergent situation, a response will be given within 48 hours of receipt of such formal complaint. Contact NMRHCA at:

Executive Director, NMRHCA
4308 Carlisle Blvd. NE, Suite 104
Albuquerque, NM 87107
1-800-233-2576
FAX: 1-(505)-884-8611

Filing Requirements for External Review of Adverse Determinations by an IRO

When required by the medical exigencies of the case. If required by the medical exigencies of the case, you or your Practitioner/Provider may telephonically request an expedited review by calling the Office of Superintendent of Insurance at 1-877-673-1732.

In all other cases. To initiate an external review by an IRO, you must file a written request for external review with the Superintendent within one hundred twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the Superintendent for good cause shown.

The cost of the external review will be borne by us. You may file your request by:

Mail: Office of Superintendent of Insurance
Mailing Address: P.O. Box 1689, Santa Fe, NM 87504-1689
Physical Address: 1120 Paseo de Peralta, Room 428, Santa Fe, NM 87501
Main Phone: (505) 827-4601
Toll-free: 1-855-4-ASK-OSI

Email: **mhcb.grievance@state.nm.us**, subject: External Review Request,

Fax: Superintendent of Insurance, Attn: Office of Superintendent of Insurance – External Review Request, at (505) 827-4734

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

Other filings. Within five (5) days, you may also file any other supporting documents or information you wish to submit to the IRO for review. The IRO must send any additional information from you to Presbyterian within one (1) business day.

The Final Decision of the IRO and Grievant's Right to Hearing after Final IRO Decision
The decision of the IRO is binding upon Presbyterian as well as the grievant except to the extent that New Mexico law allows you to appeal to the superintendent for a hearing. This requirement that the decision is binding shall not preclude Presbyterian from making payment on the claim or otherwise providing benefits at any time, including after final external review decision that denies the claim or otherwise fails to require such payment or benefits. If you are dissatisfied with the denial of benefits by the IRO, you may request a hearing from the superintendent. The superintendent will automatically grant the hearing. Presbyterian will be responsible for paying for all costs associated with the hearing.

If a grievant is insured pursuant to the Health Care Purchasing Act, and the grievant requests a hearing, if a representative from the self-insured plan is not present at any pre-hearing conference or at the hearing required by OSI, Presbyterian will be deemed to speak on behalf of the self-insured plan.

You do not have to complete the internal appeal process before requesting an external review if:

- We fail to comply with requirements under federal regulations regarding denials and appeals, unless the failure to comply was a minor error that is not likely to cause prejudice or harm to you and was for good cause or a situation beyond our control, or
- We agree to waive the requirements for the internal appeal(s), or
- You are eligible for an urgent internal appeal, and request both an urgent internal appeal and urgent external review at the same time. You will not be charged for pursuing an external review.

Administrative Grievance Review Procedures
If you are dissatisfied with a decision, action or inaction of Presbyterian Health Plan regarding a matter that does not involve the denial, reduction or termination of a requested health service, then you have the right to request, orally or in writing, that Presbyterian Health Plan internally review

the matter. First, a Presbyterian Health Plan representative will review the Administrative Grievance and provide you with a written decision within 30 calendar days from receipt of the Administrative Grievance.

If you are dissatisfied with this decision, you may file a request for reconsideration from Presbyterian Health Plan. Presbyterian Health Plan will appoint a reconsideration committee to review the Administrative Grievance and will schedule a hearing. The reconsideration committee shall schedule and hold a hearing within fifteen (15) working days after receipt of a request for reconsideration. Presbyterian Health Plan will mail you a written decision within seven working days after the hearing.

External Review by NMRHCA

If any party to the original Appeal declines to accept the decision of the Grievance Committee, that party has 30 days in which to file a formal complaint with NMRHCA. Upon receipt of the formal complaint, NMRHCA will review the case and respond to the parties involved within 30 days. If the formal complaint is due to an emergent situation, a response will be given within 48 hours of receipt of such formal complaint. Contact NMRHCA at:

Executive Director, NMRHCA
4308 Carlisle Blvd. NE, Suite 104
Albuquerque, NM 87107
1-800-233-2576
FAX: 1-(505)-884-8611

External Review by the Superintendent (Administrative Grievance Reviews)

If you are dissatisfied with Presbyterian Health Plan or NMRHCA's internal review of your Grievance, you may request an external review by the New Mexico Superintendent of Insurance by filing a written request within 20 working days of receipt of the written reconsideration decision. You may file your request by:

Mail:	Office of Superintendent of Insurance Mailing Address: P.O. Box 1689, Santa Fe, NM 87504-1689 Physical Address: 1120 Paseo de Peralta, Room 428, Santa Fe, NM 87501
Email:	**mhcb.grievance@state.nm.us**, Attn: Office of Superintendent of Insurance
Fax:	Superintendent of Insurance, Attn: Office of Superintendent of Insurance – External Review Request, at (505) 827-4734

You will need to provide copies of the decisions made by the Presbyterian Health Plan and the NMRHCA and any other supporting documentation or information. You may contact the Managed Health Care Bureau to assist you in this process.

The Superintendent will issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review.

Retaliatory Action

Presbyterian Health Plan shall not take any retaliatory action against you for filing a Grievance under this health benefits plan.

SECTION 7
MEMBER RIGHTS AND RESPONSIBILITIES

A. 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 referral or 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 referrals and **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. Participate with Providers in decision making regarding their health care.

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

11. Refuse care, treatment, or medications after the Practitioner has explained the care, treatment or other advice in language the Member understands.

12. Refuse the care of a specific Provider.

13. Be informed of the potential consequences of such refusal as outlined in this *Member Benefit Booklet*.

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

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

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

17. 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.

18. 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 *Member Benefit Booklet*.

19. 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.

20. 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.

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

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

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

B. Member Responsibilities:

All Members must:

1. Review this *Member Benefit 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 *Member Benefit 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. A Participating 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 Coinsurance 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.

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

APPEAL means a request from a Member, or their representative; or a Provider for reconsideration of an adverse organizational determination (denial, reduction, suspension or termination of a benefit).

APPLICATION means the form that a participant is required to complete when enrolling for Presbyterian Health Plan 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.

SECTION 8 – GLOSSARY OF TERMS

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.

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-DEPENDENCY means behaviors learned by family Members or significant others in order to survive in an environment of great emotional pain and stress when a family Member is dependent upon the use of alcohol or drugs.

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

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

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 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 *Member Benefit Booklet*, including any supplements, endorsements, addenda, or riders, for which benefits are provided, subject to the terms, conditions, limitations, and exclusions of this *Member Benefit Booklet*.

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 that 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.

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

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 participant's family who meets the requirements of Section 3 of this *Member Benefit Booklet* 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 layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) Serious jeopardy to your health, if pregnant the health of you or your unborn child; 2) Serious impairment to the bodily functions; or 3) Serious dysfunction of any bodily organ or part.

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.

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); or
- Disorders of carbohydrate metabolism (i.e. carbohydrate intolerance disorders, glycogen storage disorders, disorders of gluconeogenesis and glycogenolysis); or
- Disorders of fat metabolism.

GROUP means a bona fide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

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 health care 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.

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 behavioral illness, Alcoholism, drug abuse, or pulmonary tuberculosis, and ordinarily does not provide Hospice or rehabilitation care, and is not a residential treatment facility.

IDENTIFICATION CARD or **ID CARD** means the card issued to the covered participant 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.

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

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

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

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

LICENSED 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.

MEDICALLY NECESSARY, MEDICAL NECESSITY means Health Care Services determined by a Provider, in consultation with the health care insurer, to be appropriate or necessary, according to any applicable generally accepted principles 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 health care insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury, or disease.

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

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

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

MEMBER BENEFIT BOOKLET (MBB) means this booklet.

MENTAL HEALTH means the absence of behavioral illness. Individuals are considered mentally healthy if they are comfortable with their life situation and their behavior does not conflict with their associates or the rest of society.

NEGOTIATED FEE SCHEDULE means the contracted amount that Presbyterian Health Plan 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.

NMRHCA is the New Mexico Retiree Health Care Authority.

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 Presbyterian Health Plan 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 that supports or eliminates motion of a weak or diseased body part. Examples of Orthopedic Appliances are functional hand or leg brace, Milwaukee Brace, or fracture brace.

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

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

OUT-OF-NETWORK PROVIDER means a duly licensed health care Provider, including medical facilities, which has no agreement with Presbyterian Health Plan for reimbursement of services to Members.

OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received in a Calendar Year that is the Member's responsibility.

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.

PHOTOPHORESIS means the use of photosensitizing chemicals and special therapy to treat the blood of patients with certain cancers of the skin. The blood circulates through a computerized pheresis unit, which destroys the abnormal cells in the body as they circulate from the skin to the blood.

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

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

PROVIDER means a duly licensed Hospital, 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 Presbyterian Health Plan 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 in which services are rendered 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.

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

SERVICE AREA means the entire state of New Mexico.

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

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.

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

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

- Specialized instrumentation, endoscopic examinations, and other invasive procedures;

- Correction of fractures and dislocations; and
- Usual and related preoperative and postoperative care.

TEFRA means Federal law regarding the working aged.

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

TOTAL ALLOWABLE CHARGES means, for In-network Providers, the Total Allowable Charges may not exceed the amount the In-network Provider has agreed to accept from Presbyterian Health Plan for a service. For Out-of-network Providers, the Total Allowable Charges may not exceed the **Reasonable and Customary Charge** as determined by Presbyterian Health Plan for a service.

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 include: sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, fever, small lacerations, minor burns, severe stomach pain, swollen glands, rashes, poisoning and back pain.

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of April 14, 2003, and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the New Mexico Retiree Health Care Authority Plan (the "Plan") creates or receives about you. You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI; your privacy rights with respect to the PHI; the Plan's duties with respect to your PHI; your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS"); and the office to contact for further information about the Plan's privacy practices.

How the Plan Will Use of Disclose Your PHI

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care Provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to HHS;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations; and
- Uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages; disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or

contributed to the injury or illness; disclosures to determine if the claim for benefits are Covered under the Plan; are Medically Necessary Experimental, or Investigational; and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care Providers and conducting cost management and quality improvement activities, and customer service and resolution of internal Grievances.

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family Members, other relatives and your close personal friends if**:**

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You either have agreed to the disclosure or have been given an opportunity to object and have not objected.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted/preferred service Providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against Providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as

authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Your Privacy Rights With Respect to PHI

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family Members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your Mental Health professional during a counseling session. Psychotherapy notes do not include summary information about your Mental Health treatment.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care Provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review

rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Receive Confidential Communications

You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties With Respect to Your PHI

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.

Your Right to File a Complaint

You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information

If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the New Mexico Retiree Health Care Authority.

ACCEPTANCE PAGE

The New Mexico Retiree Health Care Authority (NMRHCA) agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the NMRHCA PPO Medical Plan.

By:

Neil Kueffner

2/15/2019
Date

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

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

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

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, the Privacy Officer and Civil Rights Coordinator is available to help you.

Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125

Phone: 1-866-977-3021, TTY: 711
Fax: 505-923-5124
Email: info@phs.org

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

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

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

PRESBYTERIAN

Aviso de no discriminación y accesibilidad

La discriminación es contra la ley

Presbyterian Health Services (Presbyterian) cumple con todas las leyes de derechos civiles federales aplicables y no discrimina sobre la base de la raza, color, nacionalidad, edad, discapacidad o sexo.

Presbyterian no excluye a las personas ni las trata de manera diferente en base a la raza, color, nacionalidad, edad, discapacidad o sexo.

Presbyterian:

- brinda ayudas y servicios gratuitos a personas con discapacidades para que se comuniquen efectivamente con nosotros, como intérpretes calificados de lenguaje de señas e información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- brinda servicios de idioma gratuito a personas cuyo idioma principal no es el inglés, como intérpretes calificados e información escrita en otros idiomas

Si necesita estos servicios, comuníquese con el Centro de servicio al miembro de Presbyterian llamando al 505-923-5420, 1-855-592-7737, TTY: 711.

Si cree que Presbyterian no le ha brindado estos servicios o lo ha discriminado en otra manera en base a la raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja llamando al Oficial de privacidad de Presbyterian y Coordinadora de derechos civiles, P.O. Box 27489, Albuquerque, NM, 87125, o llame al 1-866-977-3021, TTY: 711, fax 505-923-5124 o info@phs.org. Puede presentar una queja en persona o por correo, correo electrónico, o a los números de teléfono anteriores. Si necesita ayuda para presentar una queja, llame al 1-866-977-3021 y un representante del cliente le ayudará.

También puede presentar una queja a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE.UU. electrónicamente a través del portal de quejas de la Oficina de Derechos Civiles en ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,*** o por correo o teléfono a:

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

Línea telefónica gratis: 1-800-368-1019, 1-800-537-7697 (TDD)
Los formularios de quejas están disponibles en ***http://www.hhs.gov/ocr/office/file/index.html***.

PRESBYTERIAN

Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 505-923-5420, 1-855-592-7737 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420，1-855-592-7737 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: 505-923-5420، 1-855-592-7737 رقم هاتف الصم والبكم (TTY: 711).
Korean	주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오 .
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420、1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	:ृ द्ध आप दिदी बोलते ि तो आपके लए मुफ्त म भ ष स त सेव एं ि। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल कर।
Farsi	توجه: گرینوبلواسی گفتگو می‌کنید، تسهیـ ن برای شما فراهم می باشد. با 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).

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