Presbyterian Health Plan

Summary Plan Description

ALBUQUERQUE PUBLIC SCHOOLS
PPO MEDICAL PLAN
HWP10010 & HWP10046

EFFECTIVE JANUARY 1, 2018

Offered by Albuquerque Public Schools
Administered by Presbyterian Health Plan

MPC071947

WELCOME

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

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

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

This booklet is intended to provide you with an easy to understand explanation of the Plan effective January 1, 2018. Every effort has been made to make these explanations as accurate as possible. In order to have a complete view of your medical plan benefits as an APS employee, in addition to this Summary Plan Description, you need to obtain a copy of the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide. These documents are available on the APS website at http://www.aps.edu/human-resources/benefits or from the APS Employee Benefits Department. If any conflict should arise between this booklet and the claims administrative procedures of our Claims Administrator, Presbyterian Health Plan, Inc., or if any provision is not covered or only partially covered in this booklet, the terms of the Professional Services Agreement between Albuquerque Public Schools and Presbyterian Health Plan, Inc., and the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide will govern in all cases.

The APS medical plan is a Three Tier Option Plan. Under this Preferred Provider (PPO) option plan, you may use providers in the Presbyterian Preferred network, the Presbyterian Nationwide PPO network or from an out-of-network provider. You will pay the lowest out-of-pocket costs when using a participating provider in the Presbyterian Preferred network, but have the flexibility to see providers in the Presbyterian Nationwide PPO network or out-of-network. (Through-out this booklet, and in other literature, you may see the Presbyterian Preferred network referred to as Tier I, the Presbyterian Nationwide PPO network referred to as Tier II, and out-of-network referred to as Tier III.)

This booklet does not imply a contract of employment. APS reserves the right to terminate, modify, or change this Plan or any provision of this Plan at any time. If changes are made, APS or Presbyterian Health Plan will notify you of those changes.

It is your responsibility to read and understand the terms and conditions in this booklet. We urge you to read it carefully and use it to make well-informed benefit decisions for you and your family. If you have questions after you have read this Summary Plan Description, please call the Presbyterian Health Plan Customer Service Center at **(505)-923-5600** (in Albuquerque), or toll-free at 1-888-275-7737. TTY users may call 1-877-298-7407. You may also contact the APS Employee Benefits Department if you have general questions.

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2018 APS Three Tier Option Plan

Administrative Services for the Albuquerque Public Schools self-funded medical plan are provided by Presbyterian Health Plan.		Tier I Presbyterian Preferred Network	Tier II Presbyterian Nationwide PPO Network	Tier III Out-of-Network[7]
Deductible	Annual Member Deductible (calendar year)			
	Single	$250	$1,500	$4,000
	Two-party	$500	$3,000	$8,000
	Family	$750	$4,500	$12,000
	• The deductible does not apply to Preventive Care Services or Prescription Drugs. • Copayments do not apply towards deductible. • Except for Preventive Care and those services where a copayment applies, the deductible must be met before benefit payment is made by the plan (coinsurance applies). • After each family member meets his or her individual plan deductible, the plan will pay a percentage of his or her claims and the member will pay applicable coinsurance until the out-of-pocket maximum is met. • After the family plan deductible has been met, the plan will pay a percentage of each individual's claims and the member(s) will pay applicable coinsurance until the out-of-pocket maximum is met. • Deductible amounts do not cross-accumulate between Tier I, Tier II and Tier III.			
Coinsurance		You pay 20% and the Plan pays 80% after the annual deductible is met	You pay 30% and the Plan pays 70% after the annual deductible is met	You pay 50% and the Plan pays 50% after the annual deductible is met
Out-of-Pocket Maximum	Annual Out-of-Pocket Maximum			
	Single	$3,000	$4,500	$8,500
	Two-Party	$6,000	$7,875	$14,875
	Family	$9,000	$11,250	$21,250
	• The medical plan copayments, deductible and coinsurance apply to the annual out-of-pocket maximum. • Prescription drug copayments or coinsurance do not apply to the medical plan out-of-pocket maximum. The prescription drug plan includes a separate out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of that individual's covered expenses. • After the family out-of-pocket maximum has been met, the plan will pay 100% of each family member's covered expenses. • Amounts do not cross apply between Tier I/Tier II and Tier III.			
Physician Services	Non-Specialist • Primary Care Physician (PCP) selection not required	$15 office visit copay	$25 office visit copay	50% coinsurance after deductible
	Specialist • Referral not required	$40 office visit copay	$40 office visit copay	50% coinsurance after deductible
	Surgery in Office	Included in office visit copay	Included in office visit copay	50% coinsurance after deductible
	Injectable drugs administered in physician's office	Copay based on place of service	Copay based on place of service	50% coinsurance after deductible
	Self-injectable drugs (specialty pharmaceuticals) can be ordered through the prescription drug plan	Refer to the prescription drug plan		
Preventive Care Services[1]	• Routine Physical • Annual women's exam • Annual men's exam including PSA • Related laboratory tests including x-rays (includes routine pap tests, cholesterol tests, urinalysis, mammogram, colonoscopy, etc.) • Well childcare including vision and hearing screenings (through age 21) • Immunizations • Health education and counseling (including smoking/tobacco cessation education) • Family planning	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible

ALBUQUERQUE PUBLIC SCHOOLS

2018 APS Three Tier Option Plan

Women's Health Care	Contraceptive methods[1] (preferred agents) • Intrauterine devices (IUD) • Hormone contraceptive injections • Inserted contraceptive devices • Implanted contraceptive devices • Generic birth control Breast feeding support[6] • Supplies and counseling for one year after delivery	Plan pays 100% (prescription medications are covered under the prescription drug plan)	Plan pays 100% (prescription medications are covered under the prescription drug plan)	50% coinsurance after deductible
Outpatient Diagnostic Testing	Advanced Radiology[2] (i.e., PET, MRI, CT scans) • Medically necessary outpatient imaging tests	$100 copay per day, then 20% coinsurance after deductible	$100 copay per day, then 30% coinsurance after deductible	$100 copay per test, then 50% coinsurance after deductible
	Other Laboratory	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
	Other X-Rays	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
Hospital Services	Hospitalization[2] • Includes room and board, inpatient physician care–physician visits, surgeon, anesthesiologist, laboratory tests and X-Rays	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Inpatient Rehabilitation Services[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Observation Stay[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Sleep Studies	Inpatient[2] Sleep labs (two nights)[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Surgical Services	Inpatient Surgery[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Outpatient Surgery[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Office Surgery	Included in office visit copay	Included in office visit copay	50% coinsurance after deductible
Urgent Care Services	Urgent Care Facility	$50 copay	$75 copay	$75 copay
	Non-urgent follow-up care	Subject to place of service copay or coinsurance	Subject to place of service copay or coinsurance	50% coinsurance after deductible
Emergency Services	Emergency Room[4]/Emergency observation treatment[4] • Hospital and Physician charges	$150 copay, then 20% coinsurance after Tier I deductible		
	Non-emergent follow-up care	Subject to place of service copay or deductible and coinsurance	Subject to place of service copay or deductible and coinsurance	50% coinsurance after deductible

Ambulance	Ambulance – Emergency Air Transport	20% coinsurance after Tier I deductible		
Maternity Services	Physician/Midwife Services • Delivery, prenatal and postnatal care	$40 copay – initial visit only, then the plan pays 100%	$40 copay – initial visit only, then the plan pays 100%	50% coinsurance after deductible
	Genetic Testing and Counseling	Copay based on place of service	Copay based on place of service	50% coinsurance after deductible
	Hospital Admission[2]	20% coinsurance after deductible (on the mother)	30% coinsurance after deductible (on the mother)	50% coinsurance after deductible (on the mother)
	Routine nursery care for newborn • If mother is covered under the plan • Baby is covered from birth but must be enrolled in the medical plan as quickly as possible but no later than 60 days from date of birth	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
	Extended stay charges for covered newborn • If baby is admitted to the hospital post-delivery	20% coinsurance after deductible (on the baby)	30% coinsurance after deductible (on the baby)	50% coinsurance after deductible (on the baby)
Behavioral/ Mental Health	Outpatient Services	$15 office visit copay	$25 office visit copay	50% coinsurance after deductible
	Inpatient Services[2] Partial Hospitalization[2] • Two partial hospitalizations equal one inpatient stay	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Substance Abuse	Outpatient Services	$15 office visit copay	$25 office visit copay	50% coinsurance after deductible
	Inpatient Services[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Partial Hospitalization[2] • Two partial hospitalizations equal one inpatient stay	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Residential Treatment Center[3] • Combined Tier I, Tier II and Tier III maximum of 60 days per calendar year	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Other Services	Allergy Testing and Treatment	$40 office visit copay	$40 office visit copay	50% coinsurance after deductible
	Allergy Injections only	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
	Allergy Extract preparation	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible

	Alternative Therapy[3] • Acupuncture, Chiropractic, Massage Therapy and Rolfing (combined Tier I, Tier II, and Tier III maximum of 25 visits per calendar year)	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible
Other Services (continued)	Autism Spectrum Disorders[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	• Diagnosis and treatment of autism spectrum disorder for members 19 years of age or younger (or under 22 years of age if still enrolled in high school) • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder • The habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Providers must be credentialed to provide such therapy. • Treatment must be prescribed by the member's treating physician in accordance with a treatment plan, and must be preauthorized by Presbyterian Health Plan			
	Biofeedback • For specified medical conditions only	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible
	Cardiac Rehabilitation[2]	$40 copay per session	$40 copay per session	50% coinsurance after deductible
	Pulmonary Rehabilitation[2]	$40 copay per session	$40 copay per session	50% coinsurance after deductible
	Chemotherapy and/or Radiation Therapy	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Dialysis	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Diabetes Coverage • Office visit and diabetes education	Subject to place of service copay	Subject to place of service copay	50% coinsurance after deductible
	• Diabetes medication	Refer to the prescription drug plan		
	Diabetic supplies, equipment, appliances, and services[2] • Prescribed by the attending physician • Purchased through a Durable Medical Equipment (DME) provider	Plan pays 100%	30% coinsurance after deductible	50% coinsurance after deductible
	Durable Medical Equipment (DME), orthopedic appliances, prosthetics, and functional orthotics[2] • Medically necessary services, supplies and devices • Supplies limited to a 30-day supply during a 30-day period • Rental benefits may not exceed the purchase of a new unit • Support hose limited to 6 pair (or 12 hoses) per calendar year • Mastectomy bras limited to 3 per calendar year	20% coinsurance (deductible does not apply)	20% coinsurance (deductible does not apply)	50% coinsurance after deductible
	Hearing Aids (Coverage is limited to dependents under age 21 only)	The plan pays 100% of the covered charges (including fitting and dispensing services) up to a maximum of $2,200 every 36 months per hearing impaired ear		50% coinsurance after deductible
	Home Health Care[2]/Home Intravenous Service[2] (Tier III limited to 120 visits per calendar year) • Prescribed home physician services, nursing care and rehabilitative therapy	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible

	Hospice	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible

Other Services (continued)	Bereavement Counseling[3] (Limited to 3 sessions during the hospice benefit period)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Respite Care[3] (Limited to 5 continuous days for each 60 days of hospice care. No more than two respite stays allowed.)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Infertility related services • Test performed in a laboratory • Test performed in a Non-Specialist Physician's office • Test performed in a Specialist Physician's office • (Refer to the Summary Plan Description for covered services)	Copays based on place of service	Copays based on place of service	50% coinsurance after deductible
	Physical, Occupational, and Speech Therapy[3] (combined Tier I, Tier II, and Tier III maximum of 60 visits per condition per calendar year)	$40 copay per visit up to a maximum of $400 per calendar year	$40 copay per visit up to a maximum of $600 per calendar year	50% coinsurance after deductible
	Skilled Nursing Facility[3] (combined Tier I, Tier II, and Tier III maximum of 60 days per condition per calendar year)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Tobacco Cessation[3]	Plan pays 100%	Plan pays 100%	Not covered
	• Screening for tobacco use • At least two tobacco cessation attempts per year which include: • Four tobacco cessation counseling sessions of at least 10 minutes each (telephone counseling, group counseling or individual counseling) • No prior authorization required • Tobacco cessation medications prescribed by a health care provider are covered under the prescription drug plan			
	Dental Services[2] (For limited medical conditions only)	$150 copay, then 20% coinsurance after Tier I deductible		
Pre-Existing Conditions	Pre-Existing Condition Limitations	Not Applicable		
Lifetime Maximum	Not Applicable	Certain services are subject to calendar year maximum visits or days or are limited per condition		
Transplants[5]	Coverage for human organ transplants[5] • Case Management required • Refer to Summary Plan Description for complete details on transplant coverage • Maximums apply to covered travel and lodging services	20% coinsurance after deductible	30% coinsurance after deductible	Not covered
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at 1-866-563-9297			

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

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

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

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

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by APS. For more information on WHCRA benefits, contact your medical plan (see the phone number on your ID card) or contact the APS Employee Benefits Department.

Health Management

Presbyterian Health Plan, Inc. (PHP) provides members a number of tools to help better manage all health conditions, including:

- Direct access to medical advice any time, day or night through NurseAdvice[sm] New Mexico – 1-866-221-9679.
- Help with managing chronic conditions through our internal disease management program Presbyterian Healthy Solutions – (505) 923-5487 or 1-800-841-9705.
- Useful diabetes education and support through our Certified Diabetes Educators via the Diabetes Resource Line – (505) 923-5017 or toll-free at 1-866-634-2617.

Albuquerque Public Schools (APS) provides group health care coverage through the Three-Tier Option Medical Plan (Plan) administered by Presbyterian Health Plan, Inc.

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

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

- Providers are Physicians, Hospitals, and other Health Care Professionals or facilities that provide Health Care Services.
- In-network Providers have contractual agreements with Presbyterian Health Plan, Inc., and allow lower Out-of-pocket expenses and additional benefits for covered persons. Under this Three-Tier Option (PPO) plan, you may use in-network providers in the Presbyterian Preferred Network (Tier I), the Presbyterian Nationwide PPO network (Tier II) or out-of-network providers (Tier III). You will pay the lowest out-of-pocket costs when using a provider in the Presbyterian Preferred Network (Tier I), however also have the flexibility to see providers in the Presbyterian Nationwide PPO network (Tier II) or an out-of-network provider (Tier III).
- Out-of-network Providers do not have contractual agreements with Presbyterian Health Plan, Inc., which usually will increase the out-of-pocket expenses and limit benefits for covered persons.

This Three-Tier Option Plan allows you to choose, at the time you receive services, the level of benefits that will apply. **Your out-of-pocket costs depend on which network the provider is in: Presbyterian Preferred Network (Tier I): A narrow, more cost-effective network of providers.** Presbyterian Nationwide PPO Network (Tier II): Through PHP's partnership with the Multiplan/PHCS network (see more information below). Out-of-network (Tier III): Most costly,

but allows you to see any provider of your choice. The Presbyterian Health Plan Provider Directory lists the In-network Providers and indicates those providers that are Tier I. The Provider directory is available through the Presbyterian Web site at www.phs.org, or you can obtain one by contacting the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7:00 a.m. and 6:00 p.m. at **(505)-923-5600** (in Albuquerque), or toll-free at **1-888-275-7737**. TTY users may call **1-877-298-7407**.

Note: For a very few medical conditions there may not be a Tier I provider who can provide the needed services, in that case the member you will need to utilize a Tier II provider.

SECTION 1- INTRODUCTION

Presbyterian Health Plan contracts with MultiPlan/Physician Health Care Services (MultiPlan/PHCS), a national preferred Provider organization with over 3,500 acute care Hospitals and 900,000 practitioners. If you live or are traveling outside the State of New Mexico, and require medical attention, we encourage you to see MultiPlan/PHCS practitioners and facilities. Multiplan/PHCS Providers provide care to Presbyterian Health Plan Members at discounted rates, which help keep the cost of Medical Care down. MultiPlan/PHCS providers are included the Presbyterian Nationwide PPO Network (Tier II). Additionally, you cannot be charged for any difference between what Presbyterian Health Plan pays the Provider and what the Provider charges beyond your appropriate Tier II copayment and/or deductible and coinsurance (see Section 2 - How the Plan Works). The MultiPlan/PHCS Provider directory is available through their web site at www.multiplan.com or you can contact the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7:00 am and 6:00 p.m. at **(505) 923-5600** (in Albuquerque), or **toll-free** within New Mexico at **1-888-275-7737**. TTY users may call **1-877-298-7407**.

Please take the time to read this booklet carefully before placing it in a safe place for future reference. If you have any questions regarding this booklet, please call the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7:00 am and 6:00 p.m. at **(505) 923-5600** (in Albuquerque), or toll-free at **1-888-275-7737**. TTY users may call **1-877-298-7407**. You should call for clarification **before** services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

SECTION 2 – HOW THE PLAN WORKS

Your group health care plan is a Preferred Provider Organization or "PPO." This PPO plan allows you to choose, at the time you receive services, the level of benefit that will apply (Tier I or Tier II In-network or Tier III Out-of-network). You receive the highest benefit level with the lowest cost to you when you obtain services from a Tier I Provider.

IN-NETWORK PROVIDERS

As a Member of this Three-Tier Option PPO plan, for payment to be made you will generally **not** have claims to file or papers to fill out for medical services obtained from Tier I or Tier II In-network Providers. In-network Providers will bill Presbyterian Health Plan directly. Most doctor visits, Hospital Admissions, and other medical services however, do require Coinsurance and/or Copayments 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 can be found in the *Summary of Benefits* 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.

In-network providers include those providers in the Presbyterian Preferred Network (Tier I) and Presbyterian Nationwide PPO Network (Tier II). Please note that while MultiPlan providers are part of the Presbyterian Nationwide PPO Network (Tier II), they are out-of-network providers. However, the deductible, copay or coinsurance you are responsible for will be at the Tier II level.

OUT-OF-NETWORK PROVIDERS

Out-of-network Providers do not have contractual agreements with Presbyterian Health Plan. Out-of-network services, as shown in the *Summary of Benefits*, apply when you obtain care from an Out-of-network Provider**.**

If you choose to receive routine care from Out-of-network Providers, payments by Presbyterian Health Plan for Covered Services will be **limited** to Medicare Allowable Amounts. For care other than Emergency or Urgent Care, you will be responsible for any balance due above the Medicare Allowable Amounts, 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 Section 7 of this document for more information on submitting such a claim.

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

WHAT IS PRIOR AUTHORIZATION?

Prior Authorization determines only the medical necessity of a procedure or an Admission and an allowable length of stay. If you or your provider obtain prior authorization for covered services, this Prior Authorization does not guarantee payment or validate eligibility for this plan. Payment and eligibility is also subject to additional requirements identified elsewhere in this document. **Services not listed as covered and services that are not Medically Necessary are not covered**.

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

- Tier I and Tier II (except MultiPlan/PHCS) Providers - The Tier I/II provider is responsible for obtaining **Prior Authorization** (when required) from Presbyterian Health Plan before providing these services to you.
- MultiPlan/PHCS Providers and other Out-of-Network providers (Tier III) – You are responsible for obtaining Prior Authorization when required when accessing services from a MultiPlan/PHCS or other Out-of-Network (Tier III) provider.

The **Prior Authorization** requirements affect whether the Plan pays for your Covered Services. However, **Prior Authorization** does not deny your right to be admitted to any Hospital.

IMPORTANT: If you have Two-Party or Family Coverage, **Prior Authorization** requirements apply to your family Members who are also covered persons.

WHAT PROCEDURES REQUIRE PRIOR AUTHORIZATION?

Prior Authorization is required as outlined in the following sections.

PRIOR AUTHORIZATION – INPATIENT

For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*.

If Presbyterian Health Plan determines that the Admission was for a covered service but Hospitalization was not Medically Necessary, **no** benefits are paid for Inpatient room and board charges and these expenses do **not** apply toward the Out-of-Pocket -Maximum provision. Other Covered Services are paid as explained in the *Summary of Benefits* and Section 4. If the Admission is not for a covered service, **no** payment is made.

NOTE:
All 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). This applies to Tier I, Tier II and Tier III Providers and facilities. Failure to obtain **Prior Authorization** may result in benefits being reduced or denied. For emergencies, Presbyterian Health Plan Behavioral Health Dept. must be notified by the end of the next business day, or as soon as reasonably possible or benefits may be denied.

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

PRIOR AUTHORIZATION – OTHER MEDICAL SERVICES

Prior Authorization requirements are subject to change at the discretion of Presbyterian Health Plan with the approval of Albuquerque Public Schools. Contact the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7:00 am and 6:00 p.m. at **(505) 923-5600** (in Albuquerque), or **toll-free** within New Mexico at **1-888-275-7737**. TTY users may call **1-877-298-7407**.

In addition to **Prior Authorization** for all Inpatient services, **Prior Authorization** is required for the following services. For certain services, **Prior Authorization** may be requested over the telephone.

For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for **Prior Authorizations** with your Provider before obtaining any of the following services:

- Bone Growth Stimulator
- Clinical Trials (Investigational/Experimental) as specified in Covered Benefits;
- Computed Axial Tomography (CAT/CT) Scans
- Detoxification (acute detoxification requiring medical intervention);
- Durable Medical Equipment, orthotic and Prosthetic Devices (also see the –Express Scripts Prescription drug coverage booklet or call them at 1-866-563-9297);
- Home health care/Home Intravenous Drugs;
- Home uterine monitoring;
- Hospice;
- Hospital Admissions (non-emergency)
- Certain injectables received in the Provider's office;
- Mental Health and Substance Abuse (All non-emergency Inpatient);
- Magnetic Resonance Imaging (MRI);
- Surgical treatment (Bariatric Surgery) for Morbid Obesity;
- Observation more than 24 hours;
- Organ Transplants
- 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 is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive Hospitalization, or have complicated discharge planning needs so that cost-effective alternative care arrangements can be made. Special care arrangements are coordinated with the Physician and may include benefits for services that are not ordinarily covered. In addition, the case management program acts to assist the patient and Physician in complex situations and coordinates care across the healthcare spectrum.

TRANSITION OF CARE

If you are a new Member and are in an ongoing course of treatment with an Out-of-network Provider, you will be allowed to continue receiving care from this Provider for a transitional period of time (usually not to exceed 90 days). Similarly, if you are in an ongoing course of treatment

with Tier I In-network Provider and that Provider becomes a MultiPlan/PHCS Provider or another 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 or of your coverage effective date as a new member. Please contact Presbyterian Health Plan's Health Services Department at 1-888-923-5757 for further information on Transition of Care.

COST SHARING FEATURES

The APS self-funded Three Tier Option Medical Plan administered by Presbyterian Health Plan (PHP) shares the cost of your health care expenses with you. The following describes the different cost-sharing methods available, as detailed in the *Summary of Benefits*.

COPAYMENT

For some services obtained from a Tier I In-network Provider or a Tier II or MultiPlan/PHCS Provider, the member pays a Copayment and the Plan pays the remainder. The Copayment is stated as a set dollar amount. See the *Summary of Benefits* for all applicable Copayments.

For a few services, both a Copayment and Coinsurance (subject to the Calendar Year Deductible) apply.

COINSURANCE

For many services provided by a Tier I In-network provider or by a Tier II or MultiPlan/PHCS Provider the member will pay coinsurance. For all services provided by Tier III Out-of-network Providers, the member will pay Coinsurance. Coinsurance 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 Calendar Year Deductible you are responsible for, and continues to be your responsibility after the Calendar Year Deductible is met. See the *Summary of Benefits* for Coinsurance amounts.

For a few services, both a Copayment and Coinsurance (subject to the applicable Calendar Year Deductible) apply.

CALENDAR YEAR DEDUCTIBLE

Some Tier I or Tier II In-network services and almost all Tier III Out-of-network services are subject to the applicable Tier I, Tier II or Tier III Calendar Year Deductible. The amount of the Tier I, Tier II or Tier III Calendar Year Deductible can be found in the *Summary of Benefits*. The applicable Deductible must be paid by you each Calendar Year toward Covered Services **before** medical plan benefits for that Member will be paid by the Three Tier Option Medical Plan (except for those services requiring only a Copayment).

Copayments paid by the member do not apply to the Calendar Year Deductible, and Deductible amounts do not cross-apply between Tier I, Tier II and Tier III services.

For Single and Two-Party Coverage, each Member must meet the applicable Tier I, Tier II or Tier III individual Deductible as outlined in the *Summary of Benefits*. For Family Coverage, an entire family meets their applicable Tier I, Tier II or Tier III Deductible when the total Deductible amount for all family Members reaches the applicable Tier I, Tier II or Tier III family amount indicated on the *Summary of Benefits*. If one Member of the family meets the individual Tier I, Tier II or Tier III Deductible, no more charges incurred by that (family) Member may be used to satisfy the applicable Tier I, Tier II or Tier III family Deductible.

OUT-OF-POCKET MAXIMUM

To protect you and your covered Dependents from the high cost of catastrophic illness, there is a maximum on the total deductible, copayments and/or coinsurance amount you must pay in a Calendar Year for Covered Services. This total amount is referred to as your Tier I, Tier II or Tier III Out-of-pocket Maximum. After your Tier I, Tier II or Tier III Out-of-pocket Maximum is reached, the Plan pays 100% up to Medicare Allowable Amounts, for Covered Services for the remainder of that Calendar Year. Please refer to your *Summary of Benefits* for your Plan's Individual, Two Party, and Family Tier I, Tier II or Tier III Out-of-pocket Maximum amounts.

The amounts are calculated per Tier as follows:

Tier I and Tier II In-network: Out-of-pocket Maximum (OOPM) includes deductible, copayments and coinsurance amounts only. Does not include charges for non-Covered Services, any penalties and any additional benefit charges such as prescription drug copayments.

Tier III Out-of-network: OOPM includes only the Out-of-network deductible, and coinsurance amounts for Covered Services. Does not include charges for Non-Covered Services, any penalties and any additional benefit charges such as prescription drug copayments and expenses in excess of Medicare Allowable Amounts.

Out-of-pocket expenses accrued under the In-network Options (Tier I and Tier II) do not accrue toward the Out-of-network (Tier III) Out-of-pocket Maximum and vice versa.

FAMILY OUT-OF-POCKET MAXIMUM

An entire family meets the applicable Tier I, Tier II or Tier III out-of-pocket limit when the total out-of-pocket amount for all family Members reaches the applicable family Tier I, Tier II or Tier III Out-of-Pocket Maximum indicated on the *Summary of Benefits*. Note: If a Member's individual Tier I, Tier II or Tier III out-of-pocket is met, no more charges incurred by that Member may be used to satisfy the family Tier I, Tier II or Tier III out-of-pocket.

The Tier I, Tier II or Tier III Out-of-Pocket Maximums are listed in the *Summary of Benefits* and includes only the Copayment, deductible and Coinsurance amounts listed in the *Summary of Benefits*. Penalty amounts, non-covered charges, any amounts over Medicare Allowable Amounts, or prescription drug Copayments are **not** included in the Tier I, Tier II or Tier III Out-of-Pocket Maximum.

CHANGES TO CALENDAR YEAR/FAMILY OUT-OF-POCKET MAXIMUM

If the Plan's Tier I, Tier II or Tier III Out-of-Pocket Maximums change during the year, then the new amounts are in effect during that same Calendar Year. This means that if you had met your lower Tier I, Tier II or Tier III Out-of-Pocket Maximums and then this Plan changes to higher Tier I, Tier II or Tier III Out-of-Pocket Maximums, you do not continue to receive the 100% payment until the increase in the Out-of-Pocket Maximum is met during the higher out-of-pocket period.

MAXIMUM BENEFITS

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

MEDICALLY NECESSARY SERVICES

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

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

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 the Medical necessity of any item or service and you may file a Grievance or complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures in Section 7.) The fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it Medically Necessary or make the expense a covered service, even though it is not specifically listed as an exclusion.

HEALTH CARE FRAUD MESSAGE

Insurance fraud may result in cost increases to the APS self-funded medical 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 APS self-funded medical plan will be charged for the tests.
- Always review the explanation of benefits (EOB) you receive from Presbyterian Health Plan. If there are any discrepancies, in particular discrepancies between the services you received and the services that are included on the EOB, call a Presbyterian Health Plan Member Services Representative.
- Be very cautious about giving information about your medical plan coverage over the telephone.

If you suspect fraud, please call the Presbyterian Health Plan Customer Service Center at 505-923-5600 or 1-800-275-7737

Federal and State Health Care Reform

SECTION 2 – HOW THE PLAN WORKS

The APS self-funded medical plan and Presbyterian Health Plan (PHP) shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affect APS's or PHP's obligations under this Summary Plan Description will be deemed automatically amended such that APS and/or PHP shall remain in compliance with the obligations imposed by such law, rule or regulation.

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

WHO IS ELIGIBLE?

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

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

Your coverage is one of the following types:

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

Eligible Dependents include:

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

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

- Married or unmarried children through the end of the month during which the child turns age 26 as follows:
  - Biological children
  - Legal adoption or legal guardianship of a child. Evidence of placement by state licensed agency, governmental agency, or a court order/decree is required.
  - Stepchildren (or otherwise eligible child(ren) of a domestic partner) or children for who you have court approved legal guardianship.

- Foster child living in the same household as a result of placement by a state licensed placement agency, so long as the foster home is appropriately licensed; evidence of placement and foster home licensure is required.
- Children for whom you have been ordered by a court of law or through administrative order to provide health care coverage.

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

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

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

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

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

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

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

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

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

ENROLLING FOR COVERAGE

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

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

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

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

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

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

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

HOW TO ENROLL DEPENDENTS

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

WHEN COVERAGE STARTS

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

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan. You must request enrollment within 60 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 60 days after marriage, birth, or adoption.

If you have any questions about this law, contact the APS Employee Benefits Department.

CHANGING YOUR COVERAGE

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

- Situations governed by HIPAA special enrollment rules.
- You, your spouse, or your Dependent children become eligible for COBRA continuation coverage.
- Judgement, decree, or order that requires accident or group health coverage for your child
- You, your spouse, or Dependent children become entitled to Medicare or Medicaid. (You may cancel coverage for the individual who becomes newly enrolled for Medicare or Medicaid coverage.)
- A significant change in the health care provided to you or your Dependents through a third party, such as your spouse's employer.
- Change in status event, but only when the change causes you or your Dependent to gain or lose eligibility for coverage. The change must correspond with the gain or loss of coverage.

SECTION 3 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Note:

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

FAMILY STATUS OR EMPLOYMENT STATUS CHANGES (QUALIFYING EVENTS)

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

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

SPECIAL ENROLLMENT/NOTICE OF EMPLOYEE RIGHTS

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

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

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

An otherwise eligible employee and Dependent(s) who did not apply for coverage when initially eligible because of other group coverage at another place of employment but who later lost their coverage through no fault of their own, may apply within 60 days if the loss of coverage is due to loss of employment/change in job status, or death of a spouse, or divorce from a spouse. This provision also applies to employees who return to work after serving active military/reserve duty.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) – (in accordance with provisions as currently may be defined under federal law)

- An employee, who chose not to enroll in the Plan for self and/or dependent(s) during a previous enrollment period because they were covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, may request coverage for self and/or any affected eligible Dependent(s) if the Dependent is eligible and was not enrolled within 60 days of the date Medicaid or CHIP coverage terminated.
- An employee who chose not to enroll in the Plan for self and/or Dependent(s) during a previous enrollment period and has become eligible for group health premium assistance under state Medicaid or state CHIP may request coverage for self and/or eligible Dependent(s) if the Dependent is eligible and was not enrolled within 60 days of becoming eligible.
- If you apply within 60 days of the date Medicaid or CHIP coverage is terminated or within 60 days of the date the employee is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later than the first day of the month following receipt of your enrollment request.

To request coverage or request enrollment, you must visit the APS Employee Benefits Department and complete an Enrollment/Change Form. You must also submit any required supporting documentation. Refer to the APS Employee Benefits Handbook or the APS Benefits Enrollment Guide for information about required supporting documentation.

ID CARD

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

When you present your card to Tier I In-network Providers, they know that you receive special benefits – they will file claims for you and will obtain any needed Admission review or other prior authorizations. When you present your card to Tier II In-network Providers or to Tier III Out-of-network providers, you are responsible for contacting Presbyterian Health Plan Member Services to request any needed Admission review or other prior authorizations. Tier II providers will generally file claims for you. Tier III providers will not file claims for you. and usually will require payment at time of service. You are responsible for any Copayments, Deductible, Coinsurance, or expenses for non-Covered Services. When you obtain services from Tier III providers they will usually will require payment at time of service and you will then need to file a claim to Presbyterian Health Plan. (Contact Presbyterian Health Plan Member Services to obtain information related to filing an Out-of-network claim.)

Your ID Care includes your member identification number and the APS group number. The reverse side of your ID Card provides the address for Presbyterian Health Plan and important telephone numbers for your use while enrolled on the Plan.

If you want additional cards or need to replace a lost card, contact a Presbyterian Health Plan Member Service Representative.

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

SECTION 4 – COVERED SERVICES

Benefits are subject to the Copayments, Deductibles, and Coinsurance listed in the *Summary of Benefits*. Please refer to Section 5 for details regarding the Limitations and Exclusions applicable to this Plan. **Any services received must be Medically Necessary to be covered.**

NOTE:
If you disagree with 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 7.

ACCIDENTAL INJURY/MEDICAL EMERGENCY CARE/URGENT CARE

MEDICAL EMERGENCY CARE

Treatment for a Medical Emergency or Accidental Injury in the emergency room of a Hospital or an Urgent Care facility is a benefit. No notification to Presbyterian Health Plan is required unless your emergency room or Urgent Care visit results in a hospital admission. Please refer to the *Summary of Benefits* for emergency services Copayment, Deductible and Coinsurance or for Urgent Care facility Copayments and/or Coinsurance. Treatment in a Physician's office or an Ambulatory Surgical Facility is also a benefit and is paid as any other illness.

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

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

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

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

No notification or **Prior Authorization** is required for Out-of-network (including out-of-state) Hospitals or treatment facilities for Medical Emergency services. However, the Member will be responsible for the Copayment, Deductible and Coinsurance as outlined on the *Summary of Benefits*.

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 require that the Member be transferred to a Hospital

participating in its Provider network, if the patient is stabilized and the transfer completed in accordance with federal law.

URGENT CARE

The Plan will reimburse for all services rendered in an Urgent Care facility or setting, unless otherwise limited or excluded, if provided by a licensed Provider and/or an appropriate facility for treating urgent medical conditions. Members may contact the Presbyterian Customer Service Center for information regarding the closest In-network facility that can provide Urgent Care.

For Urgent Care, no notification is required unless your Urgent Care visit results in a hospital admission. For care obtained from Out-of-network Urgent Care Providers, the Member will be responsible for the Deductible, Copayment and/or Deductible/Coinsurance as outlined on the *Summary of Benefits*.

ACUPUNCTURE SERVICES

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

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

AMBULANCE SERVICES

Benefits are available for professional Ambulance Services if they are Medically Necessary 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 newborn transports to a tertiary care facility.

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

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

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

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

BEHAVIORAL HEALTH AND ALCOHOLISM AND/OR SUBSTANCE ABUSE

To obtain benefits for Outpatient services related to Behavioral Health, it is not necessary to obtain **Prior Authorization**. However, all non-emergency Inpatient Behavioral Health services and Alcoholism/Substance Abuse services require **Prior Authorization.** You can call the Presbyterian Health Plan Behavioral Health Department directly at **(505) 923-5470** or toll-free **1-800-453-4347** for more information.

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. **Day/visit limitations** listed in the *Summary of Benefits* apply to the Alcoholism and/or Substance Abuse only.

Outpatient services are available from the following credentialed providers:

- Medical Doctors, Board Eligible or Board Certified in Psychiatry (M.D.);
- Licensed Psychologists (L.P.);
- Licensed Independent Social Workers (L.I.S.W.);
- Licensed Clinical Mental Health Counselors (L.P.C.C.);
- Licensed Marriage and Family Therapists (L.M.F.T.);
- Clinical Nurse Specialists (C.N.S.); and
- Licensed Alcohol & 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. Inpatient Behavioral Health Care requires **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. Please call **(505) 923-5470** or toll-free at **1-800-453-4347**. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your Physician or behavioral health provider before services are obtained.

Partial Hospitalization can be substituted for the Inpatient Behavioral Health services. Partial Hospitalization is a non-residential Hospital-based day program attended by the Member at least 3 hours a day but not more than 12 hours in any 24-hour period 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. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance

listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained.

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 mental disorder or medical condition are also covered.

ALCOHOLISM AND/OR SUBSTANCE ABUSE SERVICES

All non-emergency Inpatient Alcoholism and/or Substance Abuse services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department; failure to do so will result in benefits being reduced or denied. Discuss the need for Prior Authorization with your Physician or behavioral health provider before services are obtained.

Inpatient treatment in a Hospital or Substance Abuse treatment center requires **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained.

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 3 hours a day but not more than 12 hours in any 24-hour period, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial Hospitalization days are equivalent to one day of Inpatient care. Partial Hospitalization services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained. Please refer to the *Summary of Benefits* for day limitations.

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

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

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

BIOFEEDBACK

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

Biofeedback is a benefit only when provided by a Medical Doctor, a Doctor of Osteopathy, or a professional Psychologist.

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

CLINICAL TRIALS

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

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

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

1. Conducted under an investigational new drug application reviewed by the Food and Drug Administration;
2. A drug trial that is exempt from having such an investigational new drug application; OR
3. Is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    a. The National Institutes of Health;
    b. The Centers for Disease Control and Prevention;
    c. The Agency for Health Care Research and Quality;
    d. The Centers for Medicare & Medicaid Services;
    e. A cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs;

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; OR
g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the Secretary of Health and Human Services determines that the study has been reviewed and approved through a system of peer review that (i) is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the heist scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

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

CARDIAC/PULMONARY REHABILITATION

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

CHEMOTHERAPY/DIALYSIS/RADIATION THERAPY

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

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

CHIROPRACTIC SERVICES

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

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

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. Benefits for covered services related to the Accidental Injury are subject to the same limitations, exclusions and member cost-sharing provisions that apply to emergency room or urgent care treatment, or to other similar services when not dental-related (e.g., x-rays, medical supplies, surgical services). Injury 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 and any services required after the initial treatment must be associated with the initial accident to be covered. All covered treatments for dental trauma must be completed within 12 months of the specific traumatic injury, and all services subsequent to the initial treatment require Prior Authorization by Presbyterian Health Plan. When alternative dental or surgical procedures or Prosthetic Devices are available, the dental accident benefit allowance is based upon the least costly procedure or Prosthetic Device.
(Dental prostheses may include the placement of dental implants to restore the area of trauma *only if it is determined to be the most cost-effective restoration* to normal form and function.)

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, 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 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 under the medical plan, if determined to be primarily dental in nature and unrelated to the treatment of dental trauma. The dental procedure may be covered under your dental plan if you have dental plan coverage.

Pediatric anesthesia in a day surgical unit may be a covered benefit for pediatric dental procedures if found to be Medically Necessary.

Before a Member is admitted for care, **Prior Authorization** is required. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to

obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained. The dental procedure itself is not a covered benefit under the medical plan unless conditions for trauma or oral Surgery are met. The dental procedure may be covered under your dental plan if you have dental plan coverage.

The APS Employee Benefits Department recommends that you contact your dental plan (if you have dental plan coverage) to determine whether you have any benefits for the dental procedure. You may also wish to request a predetermination of benefits from your dental plan. You will also want to find out from Presbyterian Health Plan whether your dentist is contracted as a Tier I or Tier II provider, or whether he or she is a Tier III Out-of-network provider.

ORAL SURGERY AND TMJ TREATMENT

Oral dental Surgery benefits are available under the medical plan 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 TMJ Surgery; and
- Lingual frenectomy.

Oral dental Surgery benefits require **Prior Authorization** only if admitted. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained. Oral Surgery procedures that are covered by your dental carrier's coverage are provided *only* if a covered benefit under this medical Plan. Benefits that are covered under both your medical plan and your dental plan are payable based upon the Coordination of Benefits (COB) requirements set forth in Section 7 of this booklet.

Benefits are also available for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders to include surgical and non-surgical treatment including

diagnostic examination, x-rays, physical therapy, dental splints, and Acupuncture. Benefits do **not** include orthodontic appliances and treatment, crowns, bridges, or dentures unless the disorder is trauma related. (For treatment due to an Accidental Injury, see "Dental Accidents" in this section.)

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

DIABETES EDUCATION

Diabetes education is a covered benefit by referral and includes coverage for any Provider rendering education or instructional services for diabetes. When services are obtained from Tier I or Tier II In-network Providers, the Copayment applies to the professional Provider's services **only.** When services are obtained from Tier III Out-of-network Providers, the applicable Deductible/Coinsurance applies to all services billed.

- **Insulin Pump Training** - One initial session and one follow up session.
  Type I Diabetes - For Members 18 years of age and under, up to six visits to normalize glucose within 2 months of diagnosis; thereafter, up to one visit per month as needed to maintain control of diabetes. For Members over 18 years of age, up to six visits to normalize glucose within two months of diagnosis; then up to one visit per month for the first year following diagnosis; thereafter, up to four visits per year.
- **Type II Diabetes** - Up to four visits for initial education, plus if insulin is initiated, up to three visits for insulin start up and management; thereafter, up to four follow up visits per Calendar Year.
- **Diabetes Occurring Only During Pregnancy ("Gestational Diabetes")** - One initial visit; thereafter, two follow up visits per month. In addition, one visit within six months following delivery for conception counseling for patients planning additional children.
- **Hypoglycemia and Glucose Intolerance** - Up to three visits to provide necessary nutritional counseling to delay or prevent onset of diabetes.
- **Additional visits** - include following a 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 Attending Physician (also refer to your Prescription Drug benefits through Express Scripts) the following equipment, supplies, appliances, and services are available from a Durable Medical Equipment supplier and are covered for Members with diabetes:

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

shoe modifications when **Prior Authorization** is obtained from Presbyterian Health Plan. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained; and

- Insulin pumps when Medically Necessary and prescribed by an endocrinologist.

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

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

For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained.

Diabetic Supplies and Equipment – Pregnancy Related

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

- insulin pump supplies (not to exceed a 30-day supply purchased during any 30 day period);
- injection aids, including those adaptable to meet the needs of the legally blind;
- insulin pumps when Medically Necessary, prescribed by an endocrinologist;
- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, when **Prior Authorization** is obtained from Presbyterian Health Plan, custom molded inserts, replacement inserts, preventive devices, and shoe modifications. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before podiatric appliances are obtained.
- Blood glucose monitors.

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

Discuss the need for Prior Authorization with your provider before any of these items are obtained. Some of these items may require Prior Authorization. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*.

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

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;
- Prenatal genetic testing unless it is determined to be Investigational; (**Prior Authorization** may be required)
- Chromosome analysis, including karyotyping and molecular cytogenetic testing;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Hearing tests **only** for the treatment of an illness or Accidental Injury;
- Magnetic Resonance Imaging (MRI), (**Prior Authorization** may be required)
- Positron Emissions Tomography (PET) scans (**Prior Authorization** may be required);
- Sleep disorders; and
- Allergy testing.

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

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

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;

- Contact lenses for aphakia (those with no lens in the eye) or keratoconus;
- Sclera shells (white supporting tissue of eyeball);
- Initially, either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intra-ocular Surgery or ocular injury, and prescribed by a Physician. (Duplicates are **not covered** and replacement is covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.);
- Custom-fabricated knee-ankle-foot orthoses (AFO and/or KAFO) in accordance with existing Medicare guidelines:
- Hearing aids and the evaluation for fitting of hearing aids are covered for school aged children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount up to a maximum of $2,200 every 36 months "per hearing impaired" ear. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit;
- Stethoscopes and manual blood pressure cuffs that are prescribed by a 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.

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

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

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

For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*.

Durable Medical Equipment that is not related to diabetes care is subject to Coinsurance as shown in the *Summary of Benefits*.

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

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

FAMILY PLANNING AND RELATED SERVICES

Family planning services are covered for the following procedures:

- Injection of Depo-Provera for birth control purposes;

- Diaphragm, including fitting;
- Birth control devices, including surgical implantation and removal;
- Intrauterine devices (IUDs) or cervical caps, including fitting, insertion, and removal;
- Prenatal genetic counseling;
- Surgical sterilization procedures such as vasectomies and tubal ligations (if the tubal ligation is done during a delivery, only the Maternity Copayment applies. There will not be an additional Surgery Copayment.); and
- RU486 administered by a Physician.

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

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

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

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

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

GENETIC INBORN ERRORS OF METABOLISM DISORDERS (IEM)

Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the Limitations and Exclusions (Section 5), and **Prior Authorization** (Section 2) requirements listed in the 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 (thru Express Scripts);
- corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM); and
- nutritional management.

For prescription drug contact Express Scripts. Please refer to your *Summary of Benefits* for applicable office visit, Inpatient Hospital, Outpatient facility, and other related Copayments, Deductible and/or coinsurance.

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. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained. The following home Health Care Services **are covered:**

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

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

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

HOSPICE CARE

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

Before the Member receives Hospice care, the treating Physician or Hospice agency must request **Prior Authorization** from Presbyterian Health Plan. **Prior Authorization** requires a written

treatment program approved by the treating Physician. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained.

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

If the patient requires an extension of the benefit period, the Hospice agency must provide a new treatment plan and the treating Physician must re-certify the patient's condition to Presbyterian Health Plan. No more than one additional Hospice benefit period 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 3 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 medical plan, subject to applicable Copayment, Deductible and/or 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.

If you are admitted, **Prior Authorization** may be required. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained.

Benefits are available for a non-private room with two or more beds. Private room charges are a covered benefit only when Medically Necessary and when the private room is ordered by the admitting 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 your Out-of-Pocket Maximum.

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

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

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

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 a Tier I, Tier II or Tier III authorized facilities. Hospitalization for rehabilitation must begin within one year

after the onset of the condition and must also take place while the Member is covered under this Plan. Inpatient rehabilitation treatment must be Medically Necessary and **not** for personal convenience.

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

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

MASSAGE THERAPY

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

MATERNITY AND NEWBORN CARE

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

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

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

Under Two-Party or Family Coverage, a Dependent daughter who is enrolled on the medical plan is eligible for Maternity benefits. Coverage for the baby is not available unless the baby is eligible to be enrolled as a dependent on the APS plan.

Note:

To add coverage for your newborn child, you must enroll your child as a Dependent within 60 days of birth. To enroll the baby, visit the APS Employee Benefits Department and bring the hospital-provided Proof of Birth or the baby's birth certificate. The baby is then covered from the moment of birth. If you have Employee coverage, you must change to Two-Party Coverage; if you have Two-Party Coverage, you must change to Family Coverage; if you already have Family Coverage, you still must complete an Enrollment Form in the APS Employee Benefits Department to add your newborn as a Dependent.

If you do not enroll your newborn child within 60 days of birth, you must wait until the next Switch/Open Enrollment period held by APS to enroll the child.

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

A separate Inpatient Deductible and Coinsurance for your newborn applies only when the infant's Inpatient stay exceeds the mother's date of discharge. Additional services above and beyond routine newborn care are not subject to an additional Copayment if the infant is discharged on the same day or before the mother is discharged from the Hospital.

If your newborn stays in the Hospital longer than the mother, you must notify Presbyterian Health Plan Health Services by calling **(505) 923-5757** or toll-free **1-888-923-5757** before the mother is discharged from the Hospital, to coordinate the baby's care, or benefits may be reduced or denied.

NEWBORN AND MOTHERS HEALTH PROTECTION ACT

Hospital Length of Stay for Childbirth: Under federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your medical plan (phone number is on your ID card) to precertify the extended stay. If you have questions about this Notice, contact the APS Employee Benefits Department.

PHYSICIAN SERVICES

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

ALLERGY SERVICES

Benefits are available for direct skin (percutaneous and intradermal) and patch allergy tests and radioallergosorbent testing (RAST). Benefits also include allergy injections and extract preparation.

CHRONIC PAIN TREATMENT
Chronic pain treatment is a benefit when used for palliative care administered by a licensed Physician only.

CONTRACEPTIVE DEVICES
Benefits are available for contraceptive devices that require a prescription by a Physician including:

- IUDs;
- Diaphragms; and
- Other implantable devices.

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

INJECTABLE DRUGS
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. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*.

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 Health Services representative if you have any questions about this policy.

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

INPATIENT 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 *Summary of Benefits*.

VIDEO VISITS
Provided online between a designated Physician and patient about non-urgent healthcare matters. Benefits are available In-network ONLY, when utilizing the Presbyterian Health Plan myPRES

dashboard. Offered at $0 copayment on the APS plan, this convenient option offers a way to see a medical provider for nonemergency medical conditions via secure video through a smartphone, tablet or computer webcam. For more information, visit www.phs.org/videovisits

WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING

Weight loss management, obesity treatment, and nutritional counseling are not a benefit unless dietary advice and exercise are provided by a Physician, licensed nutritionist, or registered dietician. Weight loss management, obesity treatment, and nutritional counseling must be prescribed by a 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 APS employees. Express Scripts can be reached at 1-866-563-9297. Some Medical services require **Prior Authorization** by Presbyterian Health Plan. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained.

SECOND OPINIONS

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

PREVENTIVE SERVICES

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

Benefit payments for services listed in this section are not subject to Copayments for care obtained from Tier I or Tier II In-network Providers. If the services listed in this section are obtained from a Tier III Out-of-network Provider, applicable Deductible and Coinsurance apply. The services listed below, including the diagnosis of osteoporosis, are covered.

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

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

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines that are required to be covered are found at http://www.HealthCare.gov/center/regulations/prevention.html.

PREVENTIVE SERVICES FOR WOMEN

Well-woman visits to include adult and female-specific screenings and preventive benefits

- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery.
- Counseling for HIV, sexually transmitted diseases, and domestic violence and abuse.
- Domestic and interpersonal violence screening and counseling for all women.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
  - generic birth control
  - IUDs
  - hormone contraceptive injections
  - inserted contraceptive devices and
  - implanted contraceptive devices
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast feeding counseling.
- Sexually Transmitted Infections (STI) counseling for sexually active women.
- Sterilization services for women only. Other services during procedure are subject to copayment, deductible and/or coinsurance as outlined in the *Summary of Benefits.*
- Well–woman visits to obtain recommended preventive services for women.

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

CYTOLOGIC SCREENING (PAP SMEAR SCREENING)

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

HEALTH EDUCATION AND COUNSELING

Health education and counseling services will be provided if recommended by your treating Physician 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:
  - Control of tobacco usage ;
  - 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 Attending 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 VISION SCREENING

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

ROUTINE HEARING SCREENING

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

ROUTINE IMMUNIZATIONS

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

ROUTINE/PREVENTIVE PHYSICAL EXAMINATIONS

This benefit is not subject to an office visit Copayment when provided by a Tier I or Tier II In-network Provider. It provides coverage for routine/preventive physical, breast, gynecological and pelvic examinations as well as periodic tests to determine blood hemoglobin, blood pressure and blood glucose level. However, you will be responsible for the Tier III Deductible/Coinsurance if services are obtained from Tier III Out-of-network Provider.

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

- Screening for colorectal (intestine/gut) cancer for individuals 50-75 by testing for blood in stool every year for everyone 50 and older;
- Screening for Type 2 Diabetes;
- Lipid/Cholesterol testing at least every five years for men 35 and older, and women 45 and older;
- Screening for abdominal aortic aneurysm for men ages 65-75 who have ever smoked;
- Screening for tuberculosis; and
- Immunizations to include a flu shot every year.

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**. If APS requires an annual preventive exam for employees and enrolled spouses/domestic partners to participate in the wellness incentive program, that annual exam is covered at 100% (no patient copayment) on this plan.

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 ensure that claim payment is made and that a Copayment or Deductible and/or Coinsurance is not applied.

WELL-CHILD CARE

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

- When child is 2-5 days old;
- 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;
- During 3rd year of age at 30 and 36 months;
- Every year for ages 4 through 21.

ROLFING

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

SKILLED NURSING FACILITY

A Skilled Nursing Facility provides room and board and Skilled Nursing services for Medical Care and has one or more licensed nurses on duty at all times supervised on a 24 hour basis by a Registered Nurse (RN) or a 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 *Summary of Benefits*. Tier I In-network Providers request **Prior Authorizations** for you. If you access care from a Tier II MultiPlan/PHCS Provider or a Tier III Out-of-network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorizations** with your Physician and the Skilled Nursing Facility before obtaining services.

SMOKING/TOBACCO CESSATION

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

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

Smoking Cessation benefits are not covered when provided by Tier III providers.

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.

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.

Also, most surgeries require **Prior Authorization.** For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained.

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 benefit.

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

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

MORBID OBESITY
Benefits are available for surgical treatment of morbid obesity (bariatric Surgery) **only** when prescribed by a licensed 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. For Tier I and Tier II Providers (except MultiPlan/PHCS providers), your provider will obtain Prior Authorization for covered services when required. If you obtain services from a MultiPlan/PHCS Provider or other out-of-network providers (Tier III) it is your responsibility to obtain Prior Authorization prior to obtaining covered services. If you fail to obtain Prior Authorization when required for services provided by MultiPlan/PHCS or Tier III providers, you will be responsible for a $300 penalty in addition to any copayment, deductible or coinsurance listed in the *Summary of Benefits*. Discuss the need for Prior Authorization with your provider before services are obtained. 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.

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.

The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. A copy of the Women's Health and Cancer Rights Act of 1998 Annual Notice Reminder is included in the Summary of Benefits at the beginning of this booklet and is also included in the APS Employee Benefits Handbook and the APS Employee Benefits Enrollment Guide.

WHCRA provides that group health plan and health insurance issuers that provide coverage for medical and surgical benefits with respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).

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

NOTE:
If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review

of the Presbyterian Health Plan decision at any time. See "Grievance Procedures" in Section 7.

THERAPY

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

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

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

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

TRANSPLANT SERVICES

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

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

Organ transplant services include the recipient's medical, surgical and Hospital services; Inpatient Immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants; kidney/pancreas, 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. To be covered, transplant services must also be received within one year of the transplant or re-transplant.

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

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

In addition, benefits are available **only** when the transplant is performed at a facility with a transplant program approved by Presbyterian Health Plan. Call the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7:00 am and 6:00 p.m. at **(505) 923-5600** (in Albuquerque), or **toll-free** within New Mexico at **1-888-275-7737** for a current list of Presbyterian Health Plan approved programs. TTY users may call **1-877-298-7407**.

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

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

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

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

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

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

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

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

- Travel must occur within five days prior or no more than one year following the actual transplant.

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

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

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

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

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

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

SECTION 5 – LIMITATIONS AND EXCLUSIONS

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

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

LIMITATIONS

The following benefits have limits applied:

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

Behavioral Health services (Inpatient) require **Prior Authorization** to be considered an eligible expense under this plan.

Bereavement counseling is limited to 3 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, urinary incontinence, and craniomandibular joint and temporomandibular joint (CMJ/TMJ) disorders. Biofeedback is a benefit only when provided by a Physician, a Doctor of Osteopathy, or a professional Psychologist.

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

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

Consumable medical supplies 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 or lost through cataract or other intraocular Surgery or prescribed by a Physician as the only treatment available for keratoconus. Duplicate lenses are **not covered**; replacement is covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.

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

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

Diabetic supplies and services that require **Prior Authorization**:

- Podiatric appliances
- Orthopedic appliances
- Continuous Glucose Monitoring Systems (CGMS)

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

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

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

Hospice care benefits are limited to patients who are terminally ill as described in Section 4. **Prior Authorization** from the Plan is required or benefits will be reduced or not payable through the Plan.

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

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

Massage therapy benefits for covered expenses, in combination with services provided for chiropractic, Rolfing, and Acupuncture, are limited to a Calendar Year Maximum as outlined in the respective *Summary of Benefits*. In addition, in order for services to be covered under this

Plan, services must be provided by a Physical Therapist, Licensed Massage Therapist, Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine, or a Chiropractor.

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

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

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

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

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

Routine eye screenings are limited to Dependents through age 21.

Routine hearing screenings are limited to Dependents through age 21, except as outlined under "Hearing Aids" in Section 4.

Skilled Nursing Care is limited to **60 days per Calendar Year** and is subject to **Prior Authorization** by Presbyterian Health Plan.

Substance Abuse benefits for Residential Treatment Center are limited to a Calendar Year maximum as outlined in the *Summary of Benefits*. All Inpatient services require **Prior Authorization** from Presbyterian Health Plan to be considered an eligible expense under this Plan.

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

EXCLUSIONS

Any service, supply, item or treatment not listed as a covered service in Section 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 benefit, to include assistance in bathing, dressing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter.

SECTION 5 – LIMITATIONS AND EXCLUSIONS

Adoption/Surrogate expenses are not a covered benefit.

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

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

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

Autopsies are not a covered benefit under this Plan.

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

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

Behavioral training is not a covered benefit under this plan.

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

Charges

- In excess of Plan limits.
- In excess of Medicare Allowable Amounts when services are secured from –a Tier III Out-of-network Provider. (This may not apply to Emergency Medical services or Urgent Care services. See Section 4 for more information.)
- Billed 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, and infertility treatment are **not Covered** Services.

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

Convalescent care or rest cures.

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

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

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

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

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

Dependent of Dependent (grandchild) expenses are **not covered** benefits unless the grandchild 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 **or a non-member donor** are not a covered benefit under this Plan, except as specified in this document. The treating Physician or Member must obtain **Prior Authorization** from Presbyterian Health Plan before benefits for any transplant evaluation, procedure or service is provided.

Duplicate coverage including, but not limited to the following:

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

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

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

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

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

Environmental control expenses are **not covered** benefits under this Plan.

Exercise equipment is not a covered benefit under this Plan.

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

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

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

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

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

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

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

- The Plan pays 100% of the allowed up to a maximum of $2,200 every 36 months "per hearing impaired ear" for school aged dependent children.
- Coverage includes fitting and dispensing services, including ear molds as necessary to maintain optimal fit.

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

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

Home health care benefits for care that:

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

Hospice benefits are not available for the following services:

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

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

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

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

Hypnotherapy or services related to hypnosis, whether for medical or anesthetic purposes, except as covered under "Smoking/Tobacco Cessation Treatment."

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

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

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

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

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

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 to Presbyterian Health Plan 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 visit limitations outlined in the *Summary of Benefits*.

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

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

Medically unnecessary services: This Plan does not cover services that are not Medically Necessary as defined in Section 2, unless such services are specifically listed as covered.

Membership fees are not a covered benefit under this Plan.

Meniscal Transplants are not a covered benefit 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 screenings, and physicals.

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

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

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

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

Non-prescription and over the counter drugs are not covered on this Plan. This also includes:

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

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

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

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

Obesity treatment is not a covered benefit under this Plan except as listed in Section 4.

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

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

Orthoptics are not a covered benefit under this Plan.

Orthotripsy is not a covered benefit under this Plan.

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

Personal trainers are **not covered** under this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

Sperm storage is not a covered benefit under this Plan.

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

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

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

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

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

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

Unreasonable charges will not be covered by this Plan.

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

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

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

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

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

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

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

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

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

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

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (The Albuquerque Public Schools medical plan may pay claims during the appeal process on the condition that you sign a reimbursement agreement with Presbyterian Health Plan as the claims administrator for the Plan.)

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

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

NOTE:
This "Work-related condition" exclusion does not apply to a member who is 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. That member may need to provide documentation showing that they have waived Workers' Compensation and that they are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

SECTION 6 – TERMINATION

WHEN COVERAGE ENDS

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

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

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

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

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

Refer to the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide for additional information regarding your options for continuation coverage, when the Plan can end your coverage for cause, special circumstances such as leave of absence, and the possible consequences of not providing timely notice to the APS Employee Benefits Department when you or a covered Dependent have a status change that impacts eligibility for coverage under this Plan.

SECTION 6 – TERMINATION

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

HOW TO DIS-ENROLL

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

CERTIFICATE OF COVERAGE

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

LEAVE OF ABSENCE

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

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

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

CONTINUATION OF COVERAGE UNDER COBRA

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

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

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

SECTION 6 – TERMINATION

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

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

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

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

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

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

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

If you elect to enroll for COBRA continuation coverage, APS is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family Members. The COBRA law requires that you be given the opportunity to maintain continuation of coverage for a maximum of 36 months, unless you lost group health care coverage due to a termination of employment or reduction in hours, in which case the required continuation coverage period is 18 months, unless you have been determined to be disabled under the Social Security Act, in which case the required continuation coverage period is 29 months. However, this law also provides that your continuation coverage may end for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees;
- The premium for your continuation coverage is not paid on time;
- You become covered under another group health plan;
- You become entitled to Medicare benefits (coverage may continue for your spouse); or
- You are determined to no longer be disabled (shortens the extended period).

SECTION 6 – TERMINATION

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

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

SECTION 7 – FILING CLAIMS

As a Member of this Plan, for payment to be made you will generally **not** have claims to file or papers to fill out for medical services obtained from Tier I or Tier II In-network Providers. In-network Providers will bill Presbyterian Health Plan directly. If you access care from a Tier III Out-of-network Provider (such as in an emergency or when you elect to see a particular Provider even through that Provider is a Tier III Out-of-network Provider), you will have to file a claim yourself.

EMERGENCY SERVICES OR OUT-OF-NETWORK PROVIDERS

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

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

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

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

OUT-OF-NETWORK CLAIMS

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

CLAIMS OUTSIDE THE UNITED STATES

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

SECTION 7 – FILING CLAIMS

ITEMIZED BILLS

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

- Name and address of the 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.

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 to Presbyterian Health Plan, because the bills will not be 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 that you previously filed as claims, identify clearly the new charges that you are submitting.

PRESCRIPTION DRUG CLAIMS

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

HOW PAYMENTS ARE MADE

Payments to Out-of-network Providers are sent to the Out-of-network Provider, when possible. However, Presbyterian Health Plan reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits to pay anyone other than the subscriber in any circumstances.

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

If you obtain services from an Out-of-network Provider, you are responsible for any amounts greater than the Medicare Allowable amounts. (This may not apply to Emergency medical Services or Urgent Care services. See Section 4 for more information.) You are also responsible for paying all applicable Copayments, Deductibles, Coinsurance, and for any non-Covered Services. If the Provider required that you pay for services up-front, and Presbyterian Health Plan makes payment to the Provider for the claim, you will need to contact the Provider to request reimbursement of any amount owed to you. If Presbyterian Health Plan made payment to you, you are responsible for making payment to the Provider.

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

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

You may be requested to have another 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 the Plan.

COORDINATION OF BENEFITS

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

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

If a Member is currently covered under COBRA provisions, coverage ceases at the beginning of the month in which the Member either becomes enrolled for any other valid coverage, 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:

- No COB Provision. If the other valid coverage does not include a COB provision, that coverage pays first and this Plan pays secondary benefits.
- Employee/Dependent. If the Member who received care is covered as the employee under one coverage and as a Dependent under another, the employee's coverage pays first. If the Member is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a Dependent of an active employee, then the order of benefit determination is:
  - ❖ benefits of the plan of an active worker covering the Medicare beneficiary as a Dependent;
  - ❖ Medicare;
  - ❖ benefits of the plan covering the Medicare beneficiary as the policyholder or as an active or retired employee.

  If the Member has other valid coverage, please contact the other carrier's customer service center to determine if that coverage is primary or secondary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may or may not be subject to those provisions.
  - Child/Spouse – If a covered child under this health plan is covered as a spouse under another health plan, the covered child's spouse's health plan is primary over this health plan.
- 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 this rule, then the father's coverage pays first.

- 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:
  - ❖ 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.
  - ❖ 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 noncustodial parent pays last.
  - ❖ Joint Custody. When a court decree specifies that the parents share joint custody, without stating that one of the parents is responsible for the health care 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.
- Active/Inactive Employee. If the Member who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active employee under one coverage and as the Dependent of the *same* but *inactive* employee under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.
- 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 money 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 ON BENEFITS

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

If you are a working employee age 65 or over and your spouse is age 65 or over, you are eligible to continue the Albuquerque Public Schools coverage on the same basis as Members under age 65. You may also elect to drop your APS coverage within 60 days of the date you enroll for

Medicare, as long as you complete an Enrollment/Change Form and provide proof to the APS Employee Benefits Department that you have enrolled for Medicare. Benefits will end at the end of the month in which you elect to drop coverage. (If an employee drops medical plan coverage because he or she elected to enroll in Medicare, coverage will also end for an enrolled spouse/domestic partner and/or enrolled child or children; these Dependents may elect COBRA continuation coverage.)

Your third option is to both continue coverage in the APS medical plan, and enroll for Medicare. If Medicare coverage coexists with this Plan, this Plan will be primary for the employee and Medicare will be secondary. (The exception to this rule is when entitlement for Medicare is on the basis of end-stage renal disease. In that case, Medicare will be secondary until the Plan pays primary for at least 30 months from the date the Member became eligible for or entitled to Medicare on the basis of end-stage renal disease.)

EFFECT OF MEDICAID ON BENEFITS

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

SUBROGATION

When this Plan pays for your care and you have the right to recover those expenses from the person or organization causing your illness or Accidental Injury, the APS medical 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 the APS Plan's subrogation right. You must notify Presbyterian Health Plan as APS's claim administrator, if you file a claim, consult an attorney, or bring action against a third party. If contacted by Presbyterian Health Plan, you must provide all requested information. Settlement of a controversy without prior notice to Presbyterian Health Plan is a breach of this agreement. In the event that you fail to cooperate with Presbyterian Health Plan or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of the APS medical Plan, Presbyterian Health Plan may recover benefit payments from you.

ASSIGNMENT OF BENEFITS

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

FRAUDULENT APPLICATION OR CLAIM

If you knowingly make a false statement on your Enrollment/Change Form or file a false claim, such enrollment or claim may be revoked retroactively back to the date of the enrollment or claim. If a claim is paid by the APS medical Plan and it is later determined that the claim should not have been paid due to fraudulent enrollment or claim, the Member shall be responsible for full

reimbursement of the claim amount to the APS Plan. Anyone who knowingly or willfully makes any false or fraudulent statement or representations shall risk forfeiting all employee and family member rights to coverage or benefits. APS will take the appropriate disciplinary action against the offending employee.

GRIEVANCE PROCEDURES

OVERVIEW

Many Grievances or problems can be handled informally by calling Presbyterian Health Plan's Consumer Assistance Office at **(505) 923-5644** or toll-free at **1-800-356-2219**. The Managed Health Care Bureau of the New Mexico Insurance Division is also available to assist you with Grievances, questions or Complaints; call **1-800-947-4722 or (505) 827-3928**.

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

If your Grievance concerns a decision by PHP to deny, reduce or terminate a requested healthcare service 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 the health benefits plan, other than the request for Health Care Services, including but not limited to administrative practices of Presbyterian Health Plan 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, PHP's Member Services or the Consumer Assistance Office will assist you to complete the required forms. Please be advised that neither APS nor 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** or TDD for the hearing impaired at or toll-free at **1-877-298-7407.**

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 Blvd 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 Insurance Division's Managed Health Care Bureau for assistance.

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 20 working days for all other cases. If PHP's medical director decides to uphold the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the medical director's decision by telephone and mail, and will ask you whether you want a second review by a medical panel selected by PHP.

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.

External Review by the Office of Superintendent of Insurance: If you are dissatisfied with the results of the review of an Adverse Determination by PHP, you may request an external review by the Superintendent by filing a written request within 20 working days from the date you receive PHP's decision. You may file your request by:

- mail to the Office of Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, 1120 Paseo de Peralta, Santa Fe, New Mexico 87501
- completing a Managed Healthcare Complaint Form at https://www.osi.state.nm.us/consumer-assistance/forms/managed-healthcare.html
- e-mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau at osi.consumer@state.nm.us; or
- fax to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, at **(505) 827-4734.**

You will need to provide a copy of the PHP decision, a fully executed release form authorizing the Superintendent to obtain any necessary medical records from PHP or other healthcare service Provider/Practitioner, and any other supporting documentation. You may contact the Managed Health Care Bureau at 1-855-4-ASK-OSI (1-855-427-5674) to assist you in this process.

ADMINISTRATIVE GRIEVANCE PROCEDURES

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

matter. First, a PHP representative will review the Administrative Grievance and provide you with a written decision within 15 working days from receipt of the Administrative Grievance.

If you are dissatisfied with this decision, you may file a request for reconsideration by PHP. PHP will appoint a reconsideration committee to review the Administrative Grievance and will schedule a hearing. PHP will notify you of the date, time and location of the hearing and of your rights in the process. PHP will mail you a written decision within 7 working days after the hearing.

APS GRIEVANCE REVIEW PROCEDURES

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

By mail:
Albuquerque Public Schools
Attn: Employee Benefits Department
PO Box 25704
Albuquerque, NM 87125-0704
Hand-delivered:
Albuquerque Public Schools
Attn: Employee Benefits Department
6400 Uptown Blvd NE, Suite 115E
Albuquerque, NM 87110

RETALIATORY ACTION

In accordance with the Patient Protection Act, the New Mexico Administrative Code for Managed Health care 13.10.17.9 NMAC-N, 7-1-00, Presbyterian Health Plan cannot take retaliatory action against you for filing a Grievance under this health benefits plan.
Albuquerque Public Schools cannot take retaliatory action against you for filing a Grievance under this health benefits plan.

SECTION 8 - RECORDS

CREATION OF NON-MEDICAL RECORDS

Presbyterian Health Plan (PHP) shall keep Member records related to identification information that does not specifically relate to the Member's medical diagnosis or treatment. The individual Member and/or the APS Plan shall forward information periodically as may be required by PHP in connection with the administration of this Agreement.

ACCURACY OF INFORMATION

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

CONSENT FOR USE AND DISCLOSURE OF MEDICAL RECORDS

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

PROFESSIONAL REVIEW

PHP is permitted by law to use the Member's records to conduct professional/regulatory review programs for healthcare services without Member consent/authorization. Such review programs include, but are not limited to, the National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS), and the Office of Superintendent of Insurance (OSI).

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Each Member will receive a Notice of Privacy Practices that PHP issues, which will contain a statement of the Members' rights with respect to, protected health information and a brief description of how the Member may exercise their rights. In addition, the Albuquerque Public Schools HIPAA Notice of Privacy Practices is included in the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide.

WHAT IS PROTECTED HEALTH INFORMATION?

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

SECTION 8 - RECORDS

Presbyterian Health Plan keeps your PHI safe. Unless otherwise permitted or required by law, we do not disclose confidential information without your consent/authorization. Your privacy in all settings is important to Presbyterian Health Plan.

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

- request restrictions on certain uses and disclosures of PHI, although Presbyterian Health Plan is not required to agree to a requested restriction;
- receive confidential communications of PHI from Presbyterian Health Plan;
- with certain exceptions, inspect and receive a copy of PHI;
- request an amendment to PHI you believe to be incorrect or incomplete;
- receive an accounting of certain disclosures of PHI; and
- obtain a paper copy of the Notice of Privacy Practices from Presbyterian Health Plan upon request (even if the Member previously agreed to receive the Notice(s) electronically).

ACCESS TO PROTECTED HEALTH INFORMATION

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

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

- Psychotherapy Notes;
- Information gathered in reasonable expectation of, or for use in, a civil, criminal, or administrative action or proceeding; or
- PHI maintained by Presbyterian Health Plan that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 U.S.C. 263a, to the extent the provision of access to the Member would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988 (CLIA), pursuant to 42 CFR 493.3(a)(2).

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

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

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

ROUTINE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

PHP routinely uses PHI for a number of important and appropriate purposes, including:

- claims payment;
- fraud and abuse prevention;
- data collection;
- performance measurements;
- meeting state and federal requirements;
- utilization management;
- accreditation activities;
- preventive health services;
- early detection and disease management programs; coordination of care; quality assessment and measurement, including surveys of Members; research of complaints and Grievances; billing; and other stated uses; and
- responding to Member requests for information, products or services.

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

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

CONSENTS/AUTHORIZATIONS

Although consent from the Member (or Member's legal guardian/Personal Representative) is not required to use or disclose PHI for certain purposes specified in the law, practitioners and Providers shall request that the Member (or Member's legal guardian/Personal Representative) sign a consent form permitting disclosure of medical records (to the extent permitted by law) to Presbyterian Health Plan at the time of Member's first visit to the practitioner or Provider.

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

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

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

We require all participating Providers/practitioners and facilities to maintain confidential patient information in accordance with federal and state laws (including, HIV/AIDS status, mental health,

sexually transmitted diseases or alcohol/drug abuse). State and federal law prohibits further disclosure of HIV/AIDS, other sexually transmitted diseases, mental health and alcohol abuse and drug abuse information to any person or agency without obtaining specific valid written authorization for that purpose from the patient (or legal guardian/Personal Representative), or as otherwise permitted by state or federal law.

To request an Authorization Form, please contact our Presbyterian Customer Service Center. Authorization Forms will be kept in your medical record or enrollment file.

MEMBERS WHO ARE UNABLE TO GIVE CONSENT/AUTHORIZATION

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

RIGHT TO REQUEST AMENDMENTS (CHANGES) TO PROTECTED HEALTH INFORMATION

Presbyterian Health Plan recognizes your right to request amendment of PHI, or a record containing PHI, for as long as the PHI is maintained in our records. Presbyterian Health Plan Member Services will accept written requests to amend PHI. Presbyterian Health Plan must approve or deny your request to amend the disputed PHI no later than sixty (60) days after receipt of the request. If Presbyterian Health Plan is unable to take an action within the required timeframe, the Plan may take up to thirty (30) additional days, provided that, no later than sixty (60) days after receiving your request, the Plan provides you with a written statement of the reason for the delay and date by which Presbyterian Health Plan will complete its action on your request.

PROCESS FOR MEMBERS TO REQUEST AN ACCOUNTING OF DISCLOSURES OF PHI

You (or Member's legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to Member Services. With some exceptions, as described in the Notice of Privacy Practices issued by Presbyterian Health Plan, the accounting will show when PHP disclosed PHI about you to others without authorization from you.

RESTRICTION OF PHI USE OR DISCLOSURE

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

- Presbyterian Health Plan's Treatment, Payment and Healthcare Operations;
- to persons involved in your care (e.g., family Member, other relative, close personal friend, or any other person identified by the Member);

- for notification purposes of your location, general condition, or death; and
- to a public or private Entity authorized by law or its charter to assist in disaster relief efforts.

Presbyterian Health Plan is not required by law to agree to any requested restriction. If Presbyterian Health Plan does agree to honor a requested restriction, Presbyterian Health Plan will not violate such restriction, except as permitted by law. Presbyterian Health Plan will accept your

written request to restrict the use or disclosure of your PHI, or will document your verbal request in our records.

USE OF MEASUREMENT DATA

It is important for Presbyterian Health Plan to know about the illnesses of our Members to help improve the quality of care our Health Care Practitioners provide to you. Presbyterian Health Plan sometimes uses medical data (laboratory results, diagnoses, etc.) which does not identify individual Members for this purpose.

INTERNAL PROTECTION OF ORAL, WRITTEN, AND ELECTRONIC PHI ACROSS PRESBYTERIAN HEALTH PLAN

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

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

Violation of the above rules by any Member of PHP's workforce is grounds for disciplinary action, up to and including immediate dismissal.

WEB SITE INTERNET INFORMATION

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

- Website traffic statistics, including:
  - Where visitor traffic comes from;
  - How traffic flows within the website; and
  - Browser type
  - We monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful.
- Personal information you provide us with (such as your name, address, billing information, health plan Member status, etc.) if you fill out a form on the PHS website.

Presbyterian Health Plan uses your personal information to reply to your concerns. We save this information as needed to keep responsible records and handle inquiries.

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

PROTECTION OF INFORMATION DISCLOSED TO PLAN SPONSORS, EMPLOYERS, OR GOVERNMENT AGENCIES

Presbyterian Health Plan is careful not to release PHI to the APS Plan as part of routine financial and operating reports unless otherwise permitted by law. Presbyterian Health Plan policies and procedures prohibit sharing your PHI with any self-insured employer group plan sponsor (including the APS Plan) without certification from the plan sponsor that the plan's documents have been amended to include provisions specified in applicable law. If the plan sponsor has not provided such certification, Presbyterian Health Plan will only disclose summary health information that does not identify individual Members to the plan sponsor for allowable purposes. We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards as permitted by law."

SECTION 9 – MEMBERS 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 or how to obtain coverage for drugs and medicines from the pharmacy benefit manager, and how to obtain **Prior Authorizations**, when needed.

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

7. Seek care from a Non-Participating Provider and be advised of their financial responsibility if they receive services from a Non-Participating 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 Practitioner.

13. Be informed of the potential consequences of such refusal as outlined in this 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 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.

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

B.Member Responsibilities:

All Members must**:**

Review this booklet and if there are questions contact the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7:00 am and 6:00 p.m. at **(505) 923-5600** (in Albuquerque), or **toll-free** within New Mexico at **1-888-275-7737** for clarification of benefits, limitations, and exclusions outlined in this booklet. TTY users may call **1-877-298-7407**.

1. 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.

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

3. Follow the plans and instructions for care that he/she has agreed upon with his/her Provider.

4. 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.

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

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

7. Advise a Participating 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 Participating Provider of their coverage.

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

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

10. Promise that all information given to APS and/or to the Claim Administrator in Enrollment/Change Forms, questionnaires, forms or correspondence is true and complete.

SECTION 10 – 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.

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.

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 following year.

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

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

SECTION 10 – GLOSSARY OF TERMS

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

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

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

COPAY/COPAYMENT means the amount, expressed as a fixed-dollar figure, required to be paid by a Member in connection with 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 SPD, including any supplements, endorsements, addenda, or riders, for which benefits are provided, subject to the terms, conditions, limitations, and exclusions of this Summary Plan Description and to the APS Employee Benefits Handbook and/or the APS Employee Benefits Enrollment Guide.

CUSTOM-FABRICATED ORTHOSIS means an Orthosis 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.

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

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

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

DEPENDENT means any Member of a covered employee's family who meets the eligibility and enrollment requirements of the Albuquerque Public School's Plan and/or Section 3 of this Summary Plan Description, 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 includes items such as oxygen or oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

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

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

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

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

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

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

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

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

- availability, delivery or quality of Health Care Services;

- administrative practices of Presbyterian Health Plan 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 mental illness, Alcoholism, drug abuse, or pulmonary tuberculosis, and ordinarily does not provide Hospice or rehabilitation care, and is not a residential treatment facility.

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

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

INDEPENDENT CLINICAL LABORATORY means a laboratory that performs clinical procedures under the supervision of a 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. In-network Providers may be Tier I or Tier II Providers on this Three-Tier Option Plan. (Refer to Section 2 – How This Plan Works for more information on the Three-Tier Option Plan.)

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 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.

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

- it is medical in nature;
- it is recommended by the treating Physician;

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

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

MEDICARE ALLOWABLE AMOUNT the maximum dollar amount that this Plan will consider reimbursing a provider for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the provider by this Plan as it may be reduced by copayment, coinsurance, or deductible, or amount beyond the annual maximum.

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

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-network providers are Tier III Providers on this Three-Tier Option Plan.

OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received in a Calendar Year that is the Member's responsibility, which is determined by the benefit level for the services received. It **does not include** expenses in excess of negotiated fees, Medicare Allowable amounts, non-covered expenses, and specifically excluded expenses and services.

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.

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.

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

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

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

PRIOR AUTHORIZATION means the process whereby Presbyterian Health Plan or Presbyterian Health Plan's delegated Provider contractor reviews and approves, in advance, the provision of certain Covered Services to Members before those services are rendered.

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.

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.

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

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

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

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

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

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

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

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

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

TEFRA means Federal law regarding the working aged.

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

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

URGENT CARE means Medically Necessary Health Care Services provided in urgent situations for unforeseen conditions due to illness or injury that is not life threatening but require prompt medical attention.

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

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

ACCEPTANCE PAGE

Albuquerque Public Schools (APS) agrees that the provisions contained in this Summary Plan Description are acceptable and, along with the APS Employee Benefits Handbook and/or the APS Employee Benefits Guide, will be the basis for the administration of the APS Three-Tier Option PPO Medical Plan.

By:

Approved by Albuquerque Public Schools

Albuquerque Public Schools