**SMART CARE 500/10% CUSTOMIZED A**
**MHPAEA**
**LARGE**
**HMO**
**(HHH10117)**

The following *Schedule of Benefits* is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by Presbyterian Health Plan (PHP). Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

| SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117) BENEFITS AND COVERAGE | LIMITS |
|---|---|
| **ANNUAL CALENDAR YEAR DEDUCTIBLE** (For Benefits noted with a [2] the Deductible must be met before payments are made) | Individual: $500<br>Family: $1,000 |
| **ANNUAL OUT-OF-POCKET MAXIMUM –** Includes % Copayments which are subject to Deductible only. **Does not include** Deductible, all other Copayments or non-Covered charges. | Individual: $3,000<br>Family: $6,000 |
| **MAXIMUM LIFETIME BENEFIT** | Unlimited |
| **AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT MAXIMUM LIFETIME BENEFIT** | $200,000 per member per lifetime.<br>Beginning January 1, 2011 the maximum benefit shall be adjusted manually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the Bureau of Labor Statistics of the United States Department of Labor. |
| **BENEFITS AND COVERAGE** | **COPAYMENT** |
| **PHYSICIAN SERVICES** including: | |
| Office visits | |
| • Primary Care Physician (PCP) | 10% Copayment per visit[2] |
| • Specialist | 10% Copayment per visit[2] |
| Home visits | **Not Covered** |
| Outpatient surgery (In Physician's office) | Included in office visit Copayment |
| Specialty Pharmaceuticals[1] (Injectable forms administered in Physician's office) | 15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year |
| Allergy services | |
| • Testing | 10% Copayment[2] |
| • Serum (extracts) | 10% Copayment[2] |
| • Injections | Included in office visit Copayment (waived if nursing visit only) |
| Injections such as insulin, heparin and injectable antibiotics | Included in office visit Copayment (waived if nursing visit only) |
| Infertility services including drugs and injections[1] | 50% Copayment[2] |
| On-campus Student Health Center | 10% Copayment per visit[2] |
| Hospital and Skilled Nursing Care visits | 10% Copayment[2] |
| Web Visits<br>*Provided through PHP contracted Web Visits Providers as identified in the Provider Directory* | |
| • Primary Care Physician (PCP) | $7 Copayment per visit |
| • Specialist | $7 Copayment per visit |
| **HOSPITAL SERVICES –** Inpatient[1]<br>Coverage Includes:<br>• Room and Board<br>• Newborn delivery and other Hospital Obstetrical services<br>• In-Hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services<br>• Detoxification | 10% Copayment per admission[2] |

[1] Benefit Certification may be required [2] Subject to Deductible Eff 1/1/10

| SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117) BENEFITS AND COVERAGE | COPAYMENT |
|---|---|
| **MEDICAL SERVICES –** Outpatient | |
| • Surgeries[1] (at facility) | 10% Copayment per visit[2] |
| • X-ray and laboratory tests | 10% Copayment per test[2] |
| • PET[1]/CAT Scans[1] | 10% Copayment per test[2] |
| • Cardiac Cath/ GI Lab | 10% Copayment per visit[2] |
| • Radiation Therapy (Non-surgical) | 10% Copayment[2] |
| • Chemotherapy | 10% Copayment[2] |
| Specialty Pharmaceuticals[1] Oral or inhalation forms/Self-administered | 15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year |
| Specialty Pharmaceuticals[1] Intravenous (IV) | 0% Copayment |
| • Magnetic Resonance Imaging (MRI) tests[1] | 10% Copayment per test[2] |
| • Sleep Studies | 10% Copayment per study[2] |
| • Administration of blood/blood components | 10% Copayment per visit[2] |
| **RECONSTRUCTIVE SURGERY[1]** | Included in Hospital Services – Inpatient Medical Services – Outpatient, and Physician Services |
| **EMERGENCY ROOM CARE** Including trauma services | $100 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies) |
| **URGENT CARE** | |
| • Participating Provider/Practitioner | 10% Copayment per visit[2] |
| • Non-Participating Provider/Practitioner (in or out of the Service Area) | 10% Copayment per visit[2] |
| **AMBULANCE SERVICES** including: | |
| Emergency or high-risk | |
| • Ground ambulance | 10% Copayment per occurrence[2] |
| • Air ambulance | 10% Copayment per occurrence[2] |
| Inter-Facility transfer services | |
| • Ground ambulance | 0% Copayment |
| • Air ambulance | 10% Copayment per occurrence[2] |
| **CLINICAL PREVENTIVE SERVICES** | |
| Well Child Care including vision and hearing screening | $0 Copayment per visit |
| Preventive physical exam | $0 Copayment per visit |
| Adult and child immunizations | Included in office visit Copayment |
| Office Based Health education | Included in office visit Copayment |
| Family planning services | Included in office visit Copayment |
| Cytologic Screening (Pap smear) | Included in office visit Copayment |
| Human Papillomavirus (HPV) screening | Included in office visit Copayment |
| HPV Vaccine for females nine to 14 years of age | Included in office visit Copayment |
| Mammography | $0 Copayment per visit |
| Colonoscopy | $0 Copayment per visit |
| Web Visits | $7 Copayment per visit |
| *Provided through PHP contracted Web Visits Providers as identified in the Provider Directory* | |
| **WOMEN'S HEALTH CARE** | |
| Gynecological Care | 10% Copayment per visit[2] |
| In-office Obstetrical/Maternity Care/Prenatal & Postnatal care | 10% Copayment per visit[2] |
| Specialist (i.e. Perinatologist) | 10% Copayment per visit[2] |
| Cytologic (Pap Smear), Human Papillomavirus (HPV) screening, and Mammograms refer to Clinical Preventive services. | |
| Newborn Delivery and other Hospital Obstetrical services | 10% Copayment per admission[2] |

[1] Benefit Certification may be required [2] Subject to Deductible Eff 1/1/10

| SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117) BENEFITS AND COVERAGE | COPAYMENT |
|---|---|
| Implantable contraceptive devices<br>• Insertion<br>• Removal<br>Web Visits<br>*Provided through PHP contracted Web Visits Providers as identified in the Provider Directory* | <br>10% Copayment per insertion(2)<br>10% Copayment per insertion(2)<br>$7 Copayment per visit |
| **DIABETES SERVICES**<br>Office visit and Diabetes education<br>Diabetic supplies(1) (Purchased through a Participating Durable Medical Equipment Supplier)<br>Diabetic supplies including Insulin and diabetic oral agents for controlling blood sugar (Purchased through a Participating Pharmacy) | <br>Included in office visit Copayment<br>10% Copayment(2)<br><br>Generic (Preferred) - $10 Copayment<br>Brand (Preferred) - $35 Copayment<br>Non-Preferred – $55 Copayment<br>(Per 30-day supply up to the maximum dosing recommended by the manufacturer) Unless Optional Benefit Rider included, then Benefits in Rider will supersede. |
| **COVERED MEDICATIONS –** Outpatient (Purchased at a Participating Pharmacy, unless due to an emergency occurring out of the PHP Service Area)<br>• Medically Necessary Nutritional Supplements for prenatal care<br>• Insulin and diabetic oral agents<br>• Diabetic supplies (purchased through a Participating Pharmacy)<br>• Smoking cessation drugs (Limited to two (2) 90-day courses of treatment per Calendar Year)<br>• Contraceptive Drugs<br>Immunosuppressive drugs following transplant surgery<br>• Oral<br>• Injectable<br>Specialty Pharmaceuticals(1) Oral or inhalation forms/Self-administered<br>Specialty Pharmaceuticals(1) Intravenous (IV)<br>Special Medical Foods(1) | <br><br>Generic (Preferred) - $10 Copayment<br>Brand (Preferred) - $35 Copayment<br>Non-Preferred – $55 Copayment<br>(Per 30-day supply up to the maximum dosing recommended by the manufacturer) Unless Optional Benefit Rider included, then Benefits in Rider will supersede.<br><br><br><br>Generic (Preferred) - $10 Copayment<br>Brand (Preferred) - $35 Copayment<br>Non-Preferred – $55 Copayment<br>(30-day supply up to the maximum dosing recommended by the manufacturer) Unless Optional Benefit Rider included, then Benefits in Rider will supersede.<br>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year<br>15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year<br>$0 Copayment<br>50% Copayment |
| **For plans with "Covered Medication" coverage only, this plan is considered non-Creditable per Medicare Part D Guidelines. For more information regarding Medicare Part D please refer to www.cms.gov. If your employer has purchased the Optional Prescription Drug Rider please refer to that rider for Medicare Part D Creditable/Non-Creditable status.** | |
| **PRESCRIPTION DRUGS**<br>Prescription Drugs (Retail/Mail Order) – Outpatient | **Not Covered except as provided in Section IV. S (Covered Medications) of the Group Subscriber Agreement, unless the Optional Benefit Rider is included, then the Copayments listed in the rider will supersede.** |

(1) Benefit Certification may be required (2) Subject to Deductible Eff 1/1/10

| SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117) BENEFITS AND COVERAGE | COPAYMENT |
|---|---|
| **MENTAL HEALTH SERVICES**[1] | |
| Outpatient | 10% Copayment per visit[2] |
| Inpatient | 10% Copayment per admission[2] |
| Partial Hospitalization | 10% Copayment per admission[2] |
| **ALCOHOL AND SUBSTANCE ABUSE SERVICES**[1] | |
| Detoxification | |
| • Outpatient | 10% Copayment per visit[2] |
| • Inpatient | 10% Copayment per admission[2] |
| Rehabilitation | |
| • Outpatient | 10% Copayment per visit[2] |
| • Inpatient or partial hospitalization | 10% Copayment per admission[2] |
| **REHABILITATION AND THERAPY SERVICES** | |
| Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year) | 10% Copayment per session[2] |
| Dialysis/Plasmapheresis/Photophoresis | 10% Copayment per visit[2] |
| Pulmonary Rehabilitation (up to 24 sessions per Calendar Year) | 10% Copayment per session[2] |
| Short-term Rehabilitation[1] (Physical and Occupational Therapy up to 2 months per condition) | |
| • Inpatient | 10% Copayment per admission[2] |
| • Outpatient | 10% Copayment per session[2] |
| Speech and Hearing[1] Therapy (up to 2 months per condition) | 10% Copayment per session[2] |
| **TRANSPLANTS**[1] STANDARD COVERAGE | 10% Copayment per admission[2] |
| **COMPLEMENTARY THERAPIES** (Limited) | |
| Acupuncture Services (up to 20 visits per Calendar Year if Medically Necessary as specified in Section IV.E. of the Group Subscriber Agreement) | 10% Copayment per session[2] |
| Chiropractic Services (up to 20 visits per Calendar Year if Medically Necessary) | 10% Copayment per session[2] |
| Biofeedback for specific conditions | 10% Copayment per session[2] |
| **SKILLED NURSING FACILITY**[1] (Up to 60 days per Calendar Year) | 10% Copayment per admission[2] |
| **HOME HEALTH CARE SERVICES**[1]**/ HOME INTRAVENOUS SERVICES**[1] | |
| Services provided by an RN, LPN and other specified specialist | 10% Copayment[2] |
| Home intravenous services and supplies | 10% Copayment[2] |
| Specialty Pharmaceuticals[1] Oral or inhalation forms/Self-administered | 15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year |
| Specialty Pharmaceuticals[1] Intravenous (IV) | 0% Copayment |
| **HOSPICE CARE**[1] **($7,500 Lifetime Maximum)** | |
| Inpatient | 10% Copayment per admission[2] |
| In-home | 10% Copayment[2] |

[1] Benefit Certification may be required [2] Subject to Deductible Eff 1/1/10

***Refer to the Group Subscriber Agreement for a more complete description of benefits***

| SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117) BENEFITS AND COVERAGE | COPAYMENT |
|---|---|
| **DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES**[1] | 10% Copayment[2] |
| Hearing Aids (for school-aged children under age 18 or 21 years of age if still attending high school.) | Up to $2,200 every 36 months "per hearing impaired ear" |
| **EYEGLASSES AND CONTACT LENSES**[1]<br>Limited to the following:<br>• Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus, or when related to Genetic Inborn Errors of Metabolism<br>• Refraction eye exam associated with post cataract surgery or Keratoconus correction | 10% Copayment[2]<br>Included in office visit Copayment |
| **DENTAL SERVICES/(CMJ/TMJ)** (Limited) | 10%[2] |
| **FAMILY, INFANT AND TODDLER PROGRAM**<br>Family, Infant and Toddler Program (FIT): Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family and Children Health Care Services. | No Copayment<br>$3,500 per Member per Calendar Year Maximum benefit<br>Not applicable to any lifetime maximums or annual limits |
| **AUTISM SPECTRUM DISORDER**[1]<br>Treatment though or provided by:<br>• PCP<br>• Specialist<br>• Outpatient Physical Therapy<br>• Outpatient Occupational Therapy<br>• Outpatient Speech Therapy<br>• Applied Behavioral Analysis (ABA)[1]<br>Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school | 10% Copayment per visit[2]<br>10% Copayment per visit[2]<br>10% Copayment per visit[2]<br>10% Copayment per visit[2]<br>10% Copayment per visit[2]<br>10% Copayment per visit[2]<br>Up to $36,000 per member per Calendar Year |

**EXCLUSIONS FOR SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117):**

*Refer to the Group Subscriber Agreement for a more complete description of Exclusions and Limitations.*

**Any exclusion listed would not be applicable if covered under the FIT Program in accordance with that which is defined in NMAC Title 7, Chapter 30, Part 8 Health, Family and Children Care Services. Refer to your Group Subscriber Agreement for details**.

- **Alternative/complementary therapies,** except as specified in the Group Subscriber Agreement (GSA).
- **Any service**, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice.
- **Artificial aids** including speech synthesis devices except items identified in the Group Subscriber Agreement (GSA).
- **Athletic trainers**.
- **Autopsies** and/or transportation costs for deceased Members.
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.
- **Benefits and services not specified as Covered.**
- **Biofeedback**, except as specified in the Group Subscriber Agreement (GSA).
- **Cancer Clinical Trials** are limited to phase 2, 3 and 4 and must be provided for in the State of New Mexico in **accordance with the provisions set forth in the Group Subscriber Agreement (GSA).**
- **Care for conditions that State or local law requires** be treated in a public or correctional facility.
- **Care for military service connected disabilities** to which the Member is legally entitled and for which facilities are reasonably available to the Member.
- **Charges that are determined to be unreasonable by PHP.**
- **Circumcisions** performed other than during the newborn's Hospital stay unless Medically Necessary.
- **Clothing** or other protective devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not.
- **Co-dependency** treatment.
- **Convenience items.**
- **Cosmetic surgery, treatments**, devices, orthotics, and medications, including treatment of hair-loss.
- **Costs for extended warranties** and premiums for other insurance coverage.
- **Counseling –** Marriage, family, sex, pastoral/spiritual, and bereavement counseling.
- **Court ordered evaluation or treatment**, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.
- **Covered services obtained from a Non-Participating Provider/Practitioner**, except as provided in the Group Subscriber Agreement (GSA).
- **Custodial or domiciliary care.**
- **Dental care** and dental x-rays, except as provided in the Group Subscriber Agreement (GSA).
- **Dental implants**.
- **Disposable medical supplies**, except when provided in a Hospital or a Physician's office or by a home health professional.
- **Donor Sperm.**
- **Durable Medical Equipment/Prosthetics/Orthotics** except as listed as Covered in this Schedule of Benefits and the Group Subscriber Agreement – additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Elective abortions** after the 24$^{th}$ week of pregnancy.
- **Elective Home Birth** and any prenatal or postpartum services connected with an Elective Home Birth.
- **Emergency facility** used for non-emergent services.
- **Exercise equipment** and videos, personal trainers, club memberships and weight reduction programs.

**EXCLUSIONS FOR SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117):**

- **Experimental/Investigational,** as determined by PHP, drugs, medicines, treatments or procedures.
- **Extracorporeal shock wave therapy** involving the musculoskeletal system.
- **Eye movement therapy.**
- **Eye refractive procedures** including radial keratotomy, laser procedures, and other techniques.
- **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the Group Subscriber Agreement (GSA).
- **Foot care (routine)**, except as provided in the Group Subscriber Agreement (GSA).
- **"Get acquainted" visits** without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves,** unless part of a wound treatment kit.
- **Hair-loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Halfway houses.**
- **Hearing aids** and the evaluation for the fitting of hearing aids.
- **Home Sleep Studies.**
- **Home visits by a Physician.**
- **Hospice benefits are not available for the following services:** food, housing and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits), homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling.
- **Hypnotherapy** except as part of anesthesia preparation or chronic pain management.
- **Infant formula.**
- **In-vitro, GIFT and ZIFT fertilization.**
- **Lay midwife** – Services of a lay midwife or an unlicensed midwife.
- **Malocclusion treatment**, if part of routine dental care and orthodontics.
- **Massage Therapy**, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program.
- **Medical and Hospital services of a donor** when the recipient of an Organ transplant is a not a Member or when the transplant procedure is not Covered.
- **New medications** for which the determination of criteria for Coverage has not yet been established by PHP's Pharmacy and Therapeutics Committee.
- **Nutritional supplements** except as provided in the Group Subscriber Agreement (GSA).
- **Organ transplants not listed as Covered and Non-human organs,** except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures**.
- **Orthodontic appliances** and orthodontic treatment, crowns, bridges, and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Orthotics (functional foot),** except as provided in the Group Subscriber Agreement (GSA) for patients with diabetes or other significant peripheral neuropathies.
- **Orthotics/orthosis (Custom Fabricated)** except as specified in the Groups Subscriber Agreement (GSA).
- **Over-The-Counter (OTC) medications** except as specified in the Group Subscriber Agreement (GSA).
- **Personal or comfort items, services or treatments.**
- **Photophoresis** for all conditions other than mycosis fungoides.
- **Physical examinations**, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment.
- **Prescription Drugs (Outpatient),** except as described in the Covered Medications section of this Schedule of Benefits and the Group Subscriber Agreement (GSA) or as described in the Outpatient Prescription Drug Rider, if included.
- **Prescription Drugs** (as listed as Covered in this Schedule of Benefits, the Optional Prescription Drug Rider, if included, and the Group Subscriber Agreement) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available.
- **Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained.**

**EXCLUSIONS FOR SMART CARE 500/10% CUSTOMIZED A MHPAEA LARGE GROUP (HHH10117):**

- **Prescription Drugs ordered by a Non-Participating Provider** or purchased at a Non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area.
- **Prescription Drug,** compounded medications.
- **Prescription Drug replacements** due to loss, theft, or destruction.
- **Private duty nursing.**
- **Psychological testing** when not Medically Necessary.
- **Residential Treatment Centers** unless for the treatment of Alcoholism and/or Substance Abuse rehabilitation.
- **Reversals of voluntary sterilization.**
- **Services for which the Member is eligible under any governmental program** (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member or Dependent.
- **Services requiring Benefits Certification** when Benefit Certification was not obtained.
- **Sex transformation surgery and drugs** relating to sex transformation.
- **Sexual dysfunction treatment**, including medication, counseling, and clinics, except for penile prosthesis as provided in the Group Subscriber Agreement (GSA).
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler (FIT) Program. Refer to the Group Subscriber Agreement (GSA) for more information.
- **Special Medical Foods,** except as listed as Covered in the Group Subscriber Agreement (GSA) for Genetic Inborn Errors of Metabolism.
- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
- **"Telephone visits"** by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient.
- **Transportation costs** for deceased Members.
- **Travel and lodging** expense, except as provided in the Group Subscriber Agreement (GSA).
- **Vision care (routine) and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the Group Subscriber Agreement (GSA).
- **Visual training.**
- **Vocational Rehabilitation services and Long-Term Rehabilitation services.**
- **Weight reduction or control treatments**, except for Medically Necessary treatment for morbid obesity (Medications are Covered only if the Optional Prescription Drug Rider is included).
- **Work-related accidents**, injuries, occupational illness, or disease if the Member is required to be covered under workers' compensation insurance, whether or not such coverage actually exists.

***Refer to the Group Subscriber Agreement for a more complete description of Exclusions and Limitations.***

*This Schedule of Benefits and services is subject to the provisions of the Contract and cannot modify or affect the Group Subscriber Agreement in any way; nor shall you accrue rights because of any statement in or omission from this Schedule.*

Plan ID – Large HHH10190 *(for internal use)*

# Presbyterian
# Health Plan

## GROUP SUBSCRIBER AGREEMENT

## AND GUIDE TO YOUR MANAGED CARE PLAN

## SMART CARE LARGE AND SMALL GROUP
### HMO BENEFIT PLANS

Offered by Presbyterian Health Plan, Inc.

PRESBYTERIAN Health Plan

**Welcome to Presbyterian Health Plan!**

Welcome and thank you for joining Presbyterian Health Plan. Presbyterian Health Plan (PHP) is operated as a division of Presbyterian Healthcare Services, a locally owned; New Mexico-based healthcare system. PHP offers a statewide healthcare delivery system and over 17 years' experience in managed care.

PHP provides you access to a comprehensive provider network, a quality medical management program, commitment to Member service, and cost-effective, healthcare services.

As part of Presbyterian Healthcare Services, the health plan represents an organization with over 100 years of community service to New Mexicans. Presbyterian's priority has been and will continue to be improving the health of individuals, families and communities. We are working to make sure that you receive quality care and service.

This booklet is your Group Subscriber Agreement ("GSA"). Your Group Subscriber Agreement is a very important document. While your Schedule of Benefits summarizes your benefits, this document explains the details of your medical benefits as a Member of PHP. It is a good idea to keep this document in a safe place and refer to it when you have questions.

Some examples of the types of things you'll find in this document are:

- Your Rights and Responsibilities as a Member of PHP
- Details on Coverage for your Dependent Students
- What types of services require Benefit Certification
- Limitations and exclusions of Covered Benefits for your plan
- Glossary of commonly used managed care terminology

As always, if you have any questions about your benefit plan you can call Member Services at **(505) 923-5678** or toll-free at **1-800-356-2219**. These numbers are also listed on the back of your PHP ID Card. For the hearing impaired call our TTY/TDD line at **(505) 923-5699** or toll-free at **1-877-298-7407**. Our Member Services Representatives are available to answer your questions Monday through Friday from 7:00 a.m. to 6:00 p.m.

Member Services has Spanish and Navajo speaking representatives available to assist Members. Presbyterian also offers translation services for more than 140 languages. When you call Member Services, request services in the language you need.

You may also visit our website for useful health information and services. PHP is a part of the Presbyterian Healthcare Services family of companies. As a result, you can find us online at www.phs.org.

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**Presbyterian Serves to Improve the Health of Individuals, Families and Communities**.

***Some of the terms used throughout this document will be capitalized. These terms are defined in Section XVII – Glossary of terms.***

## Table of Contents

## I. INTRODUCTION

***Some of the terms used throughout this document will be capitalized. These terms are defined in Section XVII – Glossary of terms. Please take a few moments to read this section. This Section will give you a good overview of how your health plan works.***

### A. Our Agreement with You

Congratulations on choosing Presbyterian Health Plan, Inc. ("PHP"). We are pleased to welcome you and look forward to serving your healthcare needs. This booklet is your Group Subscriber Agreement ("Agreement") and describes the medical, Hospital, and related healthcare benefits that you and your eligible Dependents (if any) may receive as Enrollees. Your employer ("Group") has entered into a Contract, called a Letter of Agreement, with PHP in order to offer these benefits to you. A copy of the Group Letter of Agreement is available to you upon request if you are unable to obtain a copy of it from the Group. PHP and the Group may mutually agree to change the benefits described in this Agreement at any time and without need to obtain your consent.

### B. How the Plan Works

Your employer has contracted with PHP to provide you health Coverage through an "HMO" (Health Maintenance Organization). People who receive healthcare benefits through an HMO are sometimes called "Enrollees" or "Subscribers." This HMO requires that:

1. you must physically live or physically work in the HMO's Service Area, unless you are a Dependent and meet all of the terms and conditions for such Coverage as outlined in Section VIII. (Eligibility, Enrollment and Effective Dates),

2. all of your healthcare services be provided by contract Providers/Practitioners, except for Urgent and Emergency Health Care situations, refer to Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation/Trauma Services),

3. you select a Primary Care Physician (PCP) from the PHP Provider Directory to coordinate all of you care,

4. you pay your pre-determined Copayment at the time you receive Covered services. PHP will reimburse the Provider/Practitioner the balance for Covered services (some services may not require a Copayment).

PHP's Service Area is described in Exhibit A of this Agreement. PHP strives to work closely with Subscribers, their Covered Dependents, and their healthcare Providers/Practitioners to prevent illness and provide quality, cost-effective health care. Because of this close working relationship, PHP considers its Enrollees and Subscribers to be Members of our health plan.

To receive care under the plan, a PHP Member must select a Participating Primary Care Physician to manage his/her healthcare needs. Your Primary Care Physician will be able to meet most of these needs. A list of Providers/Practitioners who serve as Participating Primary

Care Physicians may be found in the PHP Provider Directory. Primary Care Physicians include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). As a Member of the health plan, you may choose as your Primary Care Physician any doctor or nurse Practitioner on that list. **If you do not designate a Primary Care Physician on your enrollment form, PHP will select one for you.**

As a Member of PHP, you must carefully follow all procedures and conditions for obtaining care as described throughout this Agreement. Certain procedures, described in this Agreement, require Benefit Certification. Your Participating Provider/Practitioner must obtain this Benefit Certification from PHP before providing these services to you. Refer to Section V. (Benefit Certification).

As a Member of our HMO, you will not have any claims to file or papers to fill out in order to be reimbursed for medical services obtained from Participating Providers/Practitioners. Your Participating Provider/Practitioner will bill us directly. Most doctor visits and Hospital admissions do, however, require Copayment at the time of service. The amount of your Copayment for each service can be found in your Schedule of Benefits. If the charged amount for the medical or pharmacy services provided to you is less than your Copayment amount, then you pay the lesser amount. When the Copayment is expressed as a percentage (%), the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP.

Non-Participating Providers/Practitioners may require you to pay them directly at the time of service; you will then have to file your claim for reimbursement with PHP. PHP will only pay this claim if the service provided was Certified by PHP or was due to an emergency or an urgent condition.

Please send your bill or claim to us at the following address:

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489

Participating Providers/Practitioners are not required by PHP to comply with any specified numbers, targeted averages, or maximum duration of patient visits.

## C. Important Instructions

This Agreement describes your benefits, rights and responsibilities as a Member of PHP. It also gives details on how to choose or change your Primary Care Physician, what limits are placed on certain benefits, and what services are not Covered at all. Please take the time to read this Agreement carefully and then store it in a safe place for future reference. If you have any questions after reading this Agreement, please call your Employer Group personnel/benefits office or PHP Member Services at **(505) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD for the hearing impaired at **(505) 923-5699** or toll-free at **1-877-298-7407**. You may also contact us at our website at www.phs.org.

Help is available if you need assistance with completing PHP forms, have special needs, or you need assistance in protecting your rights as a PHP Member, call a PHP **Consumer Assistance Coordinator** at **(505) 923-5678** or toll-free at **1-800-356-2219** and ask for the PHP Consumer Assistance Coordinator.

PHP may be contacted in writing at the following address:

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, New Mexico 87125-7489
Attention: Member Services Department

## D. Consumer Advisory Board

PHP has established a Consumer Advisory Board. This board meets quarterly and provides input on the products and services that PHP offers to our Members from the perspective of the Member as a consumer of healthcare. In addition, PHP shares with the Consumer Advisory Board information on how well the health plan is performing. The feedback PHP receives is valuable and helps PHP improve the health of individuals, families and communities. If you are interested in serving on our Consumer Advisory Board, please call Member Services at **(505) 923-5678**, toll-free **1-800-356-2219**, or TTY/TDD for the Hearing Impaired (**505) 923-5699**, TTY/TDD toll-free **1-877-298-7407.**

## II. MEMBER RIGHTS AND RESPONSIBILITIES

***As a Member of Presbyterian Health Plan (PHP), you have specific rights and responsibilities. This section details both.***

This information can also be found on Presbyterian's website at www.phs.org. Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your health plan. Above all, your relationship with your Provider/Practitioner is essential to good health. We encourage open communication between you and your Provider/Practitioner.

### A. Member Rights

**All PHP Members have a right to:**

1. receive information about the organization, its services, its practitioners and providers, and Member's rights and responsibilities.

2. be treated with courtesy, consideration, respect, and recognition of their dignity.

3. have their privacy respected, including the privacy of medical and financial records maintained by PHP and its healthcare Providers/Practitioners as required by law.

4. participate with treating Practitioners in making decisions about their health care.

5. candid discussion of appropriate or Medically Necessary treatment option for their condition, regardless of cost or benefit Coverage.

6. voice Complaints or Appeals about PHP or the care it provides to PHP or the superintendent and to receive an answer to those Complaints within a reasonable time.

7. make recommendations regarding the organization's Members' rights and responsibilities policy.

8. request and obtain information concerning PHP's policies and procedures regarding products, services, Participating Providers/Practitioners, Appeals procedures and other information about PHP and the benefits provided.

9. request and obtain information about any financial arrangements between PHP and its Participating Providers/Practitioners which might restrict treatment options or limit services offered to Members.

10. be told the details about what is Covered, maximum benefits and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and how to obtain Benefit Certification, when needed.

11. pay all required, pre-determined Copayments at the time services are rendered when such amounts are clearly specified by the Provider/Practitioner. In addition, request and obtain information regarding their financial responsibility, which may be the entire cost of services, if they received non-Covered services or receive services without required Benefit Certification.

12. receive affordable health care, with limits on out-of-pocket expenses.

13. seek care from a Non-Participating Provider/Practitioner and be advised of their financial responsibility if they receive services from a Non-Participating Provider/Practitioner, or receive services without required Benefit Certifcation.

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

15. select a Primary Care Physician within the limits of the Covered Benefits and Provider/Practitioner network.

16. change Primary Care Physicians by following the rules described in Section III. (General Information) item B. (How to Obtain Primary Care Services) of this Agreement.

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

18. have adequate access to qualified health professionals near where they live or work within the Service Area.

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

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

21. 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.

22. have access to services, when Medically Necessary, as determined by their primary or treating Provider/Practitioner, in consultation with PHP, 24 hours per day, seven days a week for Urgent or Emergency Health Services, and for other health services as defined by this Agreement.

23. 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 PHP.

24. receive a complete explanation of why services or benefits are denied, an opportunity to Appeal the decision to PHP, the right to a secondary Appeal, and the right to request the Superintendent of Insurance assistance and to receive an answer within a reasonable time. See Section XI. (Complaints, Grievances and Appeals).

25. receive a Certificate of Creditable Coverage when a Member's enrollment in PHP terminates.

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

## B. Member Responsibilities

**All PHP Members must:**

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

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

3. understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

4. review their Group Subscriber Agreement and if there are questions contact the Member Services Department at **(505) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD for the hearing impaired at **(505) 923-5699** or toll-free at **1-877-298-7407** or the PHP website at www.phs.org for clarification of benefits, limitations, and exclusions outlined in this Group Subscriber Agreement.

5. follow PHP's policies, procedures, and instructions for obtaining services and care.

6. notify PHP and your employer within 31 days of any change of name, address, marital status, eligible Dependents or newborns.

7. notify PHP immediately of any loss or theft of his/her PHP Identification Card.

8. refuse to allow any other person to use his/her PHP Identification Card.

9. advise a Participating Provider/Practitioner of Coverage with PHP at the time of service. Members may be required to pay for services if they do not inform their Participating Provider/Practitioner of their PHP Coverage.

10. pay all required, pre-determined Copayments at the time services are rendered when amounts are made clear at that time.

11. be responsible for the payment of all services obtained prior to the effective date of this Agreement and subsequent to its termination or cancellation. See Section XIII. (Termination) item F.

12. promise that all information given to PHP in Applications for enrollment, questionnaires, forms or correspondence is true and complete.

13. be informed of the potential consequences of providing incorrect or incomplete information to PHP, as described in Section III. (General Information) item U. (Fraud) of this Agreement.

## III. GENERAL INFORMATION

***This section gives you all the basics about your healthcare Coverage and how to obtain care.***

### A. Medical Necessity

This healthcare benefit plan helps pay for healthcare expenses that are **Medically Necessary** and **Specifically Covered** in this Agreement.

1. Medical Necessity or Medically Necessary means appropriate or necessary services as determined by a Participating Provider/Practitioner, in consultation with PHP, which are provided to you for any Covered condition requiring, according to generally accepted principles of good medical practice guidelines developed by the federal government, national or professional medical societies, boards, and associations, or any applicable clinical protocols or practice guidelines developed by PHP consistent with such federal, national and professional practice guidelines for the diagnosis or direct care and treatment of an illness, injury, or medical condition, and are not services provided only as a convenience.

   **The fact that a Provider/Practitioner has prescribed, ordered, recommended, or approved a healthcare service or supply does not make it Medically Necessary unless the Provider/Practitioner first consults with PHP.**

2. Specifically Covered means only those healthcare expenses that are **expressly listed and described** by this Agreement.

   **PHP determines whether a healthcare service or supply is a Covered Benefit. The fact that a Provider/Practitioner has prescribed, ordered, recommended, or approved a healthcare service or supply does not guarantee that it is a Covered Benefit even if it is not listed as an Exclusion.**

   **Specifically Covered Benefits** are subject to the following:

   a. the **limitations, exclusions** and other provisions of this Agreement; and

   b. payment by the Member of the Copayment amount, if any, directly to the Provider/Practitioner of healthcare services at the time services are rendered.

### B. How to Obtain Primary Care Services

To receive care under the plan, you and all Covered Member's of your family must select a Participating Primary Care Physician (PCP) to manage your healthcare needs. Primary Care Physicians include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians and Obstetricians/Gynecologists (if applicable). Establishing a relationship with your Primary Care Physician is an important part of your healthcare benefits. Remember to contact or see your PCP before you seek medical treatment. Your PCP's role extends far beyond treating you when you are ill; he or she understands the importance of preventing illness and promoting healthier lifestyles. Your PCP expects to manage all of your health concerns and develop an understanding of your health history.

You may want to ask relatives or friends if they have a PCP they would recommend. A Physician may not be a PCP for him/herself or immediate family members. If you do not designate a PCP on your enrollment form, PHP will select one for you. You may change your PCP by contacting PHP Member Services. The requested change will be effective the next business day after you call our Member Services department.

The PHP Provider Directory lists all Primary Care Practitioners name, address, phone number and specialty so you can find which PCP's are near your home or work. The directory indicates Providers/Practitioners who speak languages other than English and if a PCP is only accepting established patients. A list of Providers/Practitioners who serve as Participating Primary Care Physicians can be found on our website at www.phs.org, or by calling PHP Member Services at **(505) 923-5678**, toll-free **1-800-356-2219**, or TTY/TDD for the hearing impaired **(505) 923-5699**, TTY/TDD toll-free **1-877-298-7407**. If you want to know more about your Provider/Practitioner Member Services can tell you information such as medical school attended, residency completed, and board certification status.

## C. Specialist Care

As a Member of PHP, you must carefully follow all procedures and conditions for obtaining care from specialists and or Non-Participating Providers/Practitioners.

PHP no longer requires a paper referral from your Primary Care Physician (PCP) for your visits to specialists. However, it is important to your healthcare that your PCP is included in the decisions about the specialists that you visit. Your PCP continues to be your partner for good health and is the best person to help you determine your needs for specialty care. Effective communication about your medical history and treatment between your PCP and the specialists that provide care for you is very important so that the best decisions can be made about your medical care. We recommend that you contact your PCP's office regarding your desire to visit a specialist.

Please note that some specialists may require written referral even though PHP does not.

Certain procedures require Benefit Certification. Your Participating Provider/Practitioner must obtain this Benefit Certification from PHP before providing these services to you.

**Services of a Non-Participating Provider/Practitioner will not be Covered** unless Benefit Certification is obtained prior to receiving the services. Members may be liable for charges resulting from failure to obtain Benefit Certification for services provided by the Non-Participating Provider/Practitioner, except for Urgent or Emergency Health Services. Refer to item F. (Participating and Non-Participating Providers/Practitioners) in this Section for information regarding Benefit Certification.

## D. Women's Healthcare Provider/Practitioner

Any female Member age 13 or older may select a participating Women's Healthcare Provider/Practitioner listed as a PCP in the PHP Provider Directory as her Primary Care Physician. In addition, a female Member age 13 or older who has not selected a Women's Healthcare Provider/Practitioner as her Primary Care Physician may consult with a participating Women's Healthcare Provider/Practitioner, without a referral from her Primary Care Physician, for any gynecological or obstetrical service.

## E. Behavioral Health Services

To obtain services relating to behavioral health, Members may call the PHP Behavioral Health Unit directly at **(505) 923-5470** or toll-free at **1-800-453-4347** or self-refer to a Participating Behavioral Health Provider/Practitioner. The Behavioral Health Provider/Practitioner will be responsible for any additional Benefit Certification.

## F. Participating and Non-Participating Providers/Practitioners

Participating Providers/Practitioners, including Primary Care Physicians, specialists, facility and ancillary Providers/Practitioners, must be utilized, except in cases of an emergency. Members are responsible for paying the appropriate Copayment directly to the Provider/Practitioner at the time services are rendered.

Benefit Certification is required for certain services Covered by this Agreement. If a Participating Provider/Practitioner performs those services, that Provider/Practitioner is responsible for obtaining the Benefit Certification. If that Provider/Practitioner fails to obtain a required Benefit Certification and the claim is denied, the Member will not be held accountable for those charges.

Non-Participating Providers/Practitioners are healthcare Providers/Practitioners, including non-medical facilities, who have not entered into an Agreement with PHP to provide healthcare services to PHP Members.

Services provided by a Non-Participating Provider/Practitioner require that your Primary Care Physician request and obtain written approval from the PHP Medical Director **BEFORE** services are rendered; otherwise, you will be responsible for payment. Please refer to Section V. (Benefit Certification) for more information on Benefit Certification requirements.

Covered services obtained from a **Non-Participating Provider/Practitioner or outside the Service Area will not be Covered** unless such services are not reasonably available from a Participating Provider/Practitioner or in cases of an emergency. You will not pay higher or additional Copayments under such circumstances. If the services of a Non-Participating Provider/Practitioner are required, your Participating Physician must request and obtain Benefit Certification from the PHP Medical Director BEFORE services are performed, otherwise, those services will not be Covered by PHP and you will be responsible for payment. Before the Medical Director may deny a request for specialist services that are unavailable from a Participating Provider/Practitioner, the request must be reviewed by a specialist similar to the type of specialist to whom the Benefit Certification is requested.

In determining whether a Benefit Certification to a Non-Participating Provider/Practitioner is reasonable, PHP will consider the following circumstances:

1. Availability – The Participating Provider/Practitioner is not reasonably available to see the patient in a timely fashion as dictated by the clinical situation.

2. Competency – The Participating Provider/Practitioner does not have the necessary training or expertise required to render the service or treatment.

3. Geography – The Participating Provider/Practitioner is not located within a reasonable distance from the patient's residence. A "reasonable distance" is defined as travel that would not place the Member at any medical risk.

4. Continuity – If the requested Non-Participating Provider/Practitioner has a well-established professional relationship with the Member and is providing ongoing treatment of a specific medical problem, the Member will be allowed to continue seeing that specialist for a minimum of 30 days as needed to ensure continuity of care.

5. Any Benefit Certification requested simply for the convenience of the Member **will not be considered to be reasonable.**

If required medical services are not available from Participating Providers/Practitioners, the Primary Care Physician must request and obtain written Benefit Certification from the PHP Medical Director BEFORE the Member may receive such services. **Services of a Non-Participating Provider/Practitioner will not be Covered** unless this Benefit Certification is obtained prior to receiving the services. **Members may be liable for charges** resulting from failure to obtain Benefit Certification for services provided by the Non-Participating Provider/Practitioner.

## G. No Need to File Claim Forms When You Visit a Participating Provider/Practitioner

You won't have any claims to file or claim forms to fill out for medical services obtained from Participating Providers/Practitioners. Your Participating Provider/Practitioner will bill PHP directly. Most medical services do, however, require Copayments at the time of service. The amount of your Copayment for each service can be found in your Schedule of Benefits.

Non-Participating Providers/Practitioners may require payment in full at the time of service; you should then file your claim for reimbursement with PHP. PHP will only pay this claim if the service provided was Certified by PHP or was due to an urgent or Emergency Health Care situation.

## H. Obtaining Care After Normal Physician Office Hours

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

If Emergency Health Services are needed**,** you should call 911, or seek treatment at an emergency room. If in need of Urgent Care, you may seek treatment at an Urgent Care Center that is available and open for business. Please note that some Urgent Care Centers are not open after 8:00 p.m. In such circumstances, it may be necessary to use an emergency room for care that is needed on an urgent basis. Please refer to Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation) of this Agreement for a detailed description of Coverage for Emergency Health Services and Urgent Care.

## I. Restrictions on Services Received Outside of the PHP Service Area

Emergency Health Care services and/or Urgent Care services outside the Service Area will be Covered. For Emergency Health Care services and/or Urgent Care services received outside the Service Area, you may seek services from the nearest appropriate facility where Emergency Health / Urgent Care services may be rendered.

## J. National Healthcare Provider/Practitioner Network

When receiving Urgent or Emergency Health Services outside of the PHP Service Area you can help reduce the cost of such services by seeking care from one of our National Healthcare Provider Network Providers/Practitioners. These cost savings can help minimize future premium increases. Contact Member Services for questions about the National Healthcare Provider Network and your specific benefit plan.

## K. Dependent Student

Dependent Students attending school within the PHP Service Area may either receive care through their Primary Care Physician or at the Student Health Center. A Benefit Certification from PHP is not needed prior to receiving care from the Student Health Center.

Dependent Students attending school outside of PHP's Service Area may also receive care at the Student Health Center without Benefit Certification from PHP. Services provided outside of the Student Health Center are limited to Medically Necessary services for the initial care or treatment of Emergency Health Services or an Urgent Care situation.

For emergencies outside the Plan's Service Area, you may seek Emergency Health Services from the nearest appropriate facility where emergency medical treatment can be rendered. Refer to Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation/Trauma Services) for further information on Emergency Health Services and follow-up care.

## L. Court Ordered Coverage for Dependent Children

When a Subscriber who is eligible for family Coverage has been ordered by a court to provide health insurance Coverage for a Dependent child who is eligible for the plan, and that child **does not live in the PHP Service Area**, benefits will be administered as follows:

1. Covered services provided by Non-Participating Providers/Practitioners will be reimbursed less the appropriate Copayment up to the Reasonable and Customary Charge. The Member will be responsible for paying any amounts over Reasonable and Customary. Referrals are not required.

2. **The Member is responsible for obtaining any required Benefit Certification. Failure to do so will result in denial of payment.**

Regular plan benefits described in this Agreement apply for Dependents living in the PHP Service Area.

## M. Non-Custodial Parents

When a child has health Coverage through a non-custodial parent, PHP shall:

1. Provide such information to the custodial parent as may be necessary for the child to obtain Benefits through that Coverage;

2. Permit the custodial parent or the Provider/Practitioner, with the custodial parent's approval, to submit claims for Benefits without the approval of the non-custodial parent; And

3. Make payments on claims submitted in accordance with (2) above directly to the custodial parent, the Provider/Practitioner or the state Medicaid agency.

## N. Annual Calendar Year Deductible and Out-of Pocket Maximum

### Annual Calendar Year Deductible

Some services are subject to an annual Calendar Year Deductible. Refer to your Schedule of Benefits for these services and the amount of your annual Calendar Year Deductible. This Deductible must be paid for each Calendar Year by a Member directly to the Provider in connection with healthcare services before health benefits are paid by PHP.

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

For double or family coverage, with two enrolled Members, the Annual Deductible requirement is fulfilled when both covered Members have each met their applicable Individual Deducible, listed in the Schedule of Benefits, during the Calendar Year.

For family coverage, with three or more enrolled Members, the family Deductible, listed in the Schedule of Benefits, requirement is fulfilled when any three covered Members have each met their applicable individual Deductible during the Calendar Year.

### Annual Out-of-Pocket Maximum

The Plan includes an Annual Out-of-Pocket Maximum amount to protect you from catastrophic healthcare expenses. After your Out-of-Pocket Maximum is reached, the Plan pays 100% for Covered services for the remainder of that Calendar Year, up to the maximum benefit amounts if any. Refer to your Schedule of Benefits.

For single coverage, the Out-of-Pocket Maximum requirement is fulfilled when the Member meets the Individual Out-of-Pocket Maximum listed in the Schedule of Benefits.

For double or family coverage, with two or more enrolled Members, the annual Out-of-Pocket Maximum requirement is fulfilled when both covered Members have each met their applicable Individual Out-of-Pocket Maximum during the Calendar Year.

For family coverage, with three or more enrolled Members, the family annual Out-of-Pocket Maximum requirement is fulfilled when any three covered Members have each met their applicable individual annual Out-of-Pocket Maximum during the Calendar Year.

**The Annual Out-of-Pocket Maximum includes percentage (%) Copayments which are subject to Deductible only.** The annual Out-of-Pocket Maximum does **not** include all other Copayments (including Prescription Drug Copayments), the Deductible, penalty amounts, or non-covered charges. **You are responsible for notifying PHP when you have reached the Annual Out-of-Pocket Maximum.**

## O. Coordination of Your Medical Care

PHP maintains a staff of clinically trained medical professionals to help you meet your healthcare needs. Practitioners and nurses at PHP provide support to your Physician to coordinate your medical care. Some examples of this coordination include:

1. treatment plans for rehabilitation and therapies,

2. admission to the Hospital or Skilled Nursing Facilities,

3. the length of stay that is required,

4. emergency admissions to non-contracted Hospitals (for example, emergencies while you are on vacation),

5. Hospice care,

6. visits to Non-Participating providers/practitioners,

7. care at home following a hospitalization, and

8. disease management.

Your Physician and PHP clinical staff work together to make sure the services you receive are medically appropriate for your situation. The clinical staff at PHP also confirms that services requested are Covered by your benefit plan and that any required Benefit Certifications are in place so that your claims will be accurately processed.

The individuals involved in this process are not offered any incentive to encourage denials of service, nor do they receive compensation based on denial rates. Several factors for the review process include but are not limited to:

1. Your particular plan Coverage for the requested service.

2. Meeting the requirements of your Group Subscriber Agreement or benefit plan.

3. The service is medically appropriate for your clinical situation

4. Urgent or Emergency Health Care services, which do not require a Benefit Certification.

Other factors, which are considered, include:

1. your age;

2. complications of treatment, adequate progress of and response to treatment plan;

3. other medical conditions;

4. psychosocial situations;

5. home environment; and

6. adequate healthcare services in your area.

For your protection, these health professionals also make sure that certain medical services are not underutilized.

Additionally the practitioners and nurses who staff our Health Services department serve you by coordinating:

1. case management;

2. catastrophic care;

3. transition of care; and

4. health information/medical records.

## P. Utilization Management Procedures

PHP's Case Management department is staffed with registered nurses that coordinate Covered health services for Members with ongoing or complex diagnoses. The role of the Nurse Care Coordinator is to support and educate the Member, so the Member is able to make informed healthcare decisions. Ongoing communication and visits to Members who may have chronic illness can trigger prompt intervention and help in the prevention of avoidable episodes of illness. PHP is committed to the personal service that case management provides to its Members in need.

Our nurse care coordinators work with the Hospital discharge planners when you are in the Hospital to determine the length of stay you need and coordinate your care after you leave the Hospital.

As part of our Benefit Certification review process, our nurses evaluate your insurance claims to make sure the care you receive is Medically Necessary and part of your benefit package.

## Q. Health Management Programs

PHP's clinically trained professionals work with your doctor to help enhance your quality of life in three areas: staying healthy, living with illness, and getting better. We help you reach optimum health through preventive health services (such as mammography and childhood immunizations) as well as, with disease management for conditions such as asthma, depression, diabetes, smoking cessation, and high-risk pregnancies. If you'd like more information about these services, please call Member Services at **(505) 923-5678** or toll-free **1-800-356-2219**, or TTY/TDD **(505) 923-5699**, TTY/TDD toll-free **1-877-298-7407**, or visit our website at www.phs.org.

## R. Transition of Care/Continuity of Care

If you are a new Member and are in an ongoing course of treatment with a Non-Participating Provider/Practitioner, you will be allowed to continue receiving care from this Provider/Practitioner for a transitional period of time as set forth in Section XIV. (Continuation of Coverage) item C. (Transition of Care) of this Agreement. Similarly, if you are in an ongoing course of treatment with a Participating Provider/Practitioner and that Provider/Practitioner becomes a Non-Participating Provider/Practitioner, you will be allowed to continue care from this Provider/Practitioner for a transitional period of time as set forth in Section XIV. (Continuation of Coverage) item C. (Transition of Care) of this Agreement. In any case, the transitional period of time shall not be less than 30 days, may be longer depending on your medical needs. Please contact PHP's Health Services Department at **1-888-923-5757** for further information on Transition/Continuity of Care.

## S. Advance Directives

Advance Directives are the legal documents in which you give written instructions about your healthcare if in the future you cannot speak for yourself. You have the right to make choices about your own healthcare and the right to choose someone else to make healthcare decisions for you. Advance directives help healthcare workers care for people.

## T. Technology Assessment Committee

PHP continuously evaluates evolving medical technologies, which include medical procedures, drugs and devices. Practitioners from the PHP network and the community along with other clinical staff are responsible for this process and are known as the Technology Assessment Committee.

The Technology Assessment Committee evaluates new technologies and/or new applications of existing technologies, determines the value of the new technology, and recommends whether the technology should be a Covered Benefit of your plan. Factors to be considered include safety, comparison to existing procedures or technology, cost and effectiveness of the new technology, and clinical skills and training of those proposing to provide the new technology.

## U. Fraud

Fraud increases the cost of healthcare for everyone. PHP must cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Provider/Practitioner and Member activity.

If you suspect that a Physician, pharmacy, Hospital or other healthcare Provider/Practitioner has:

1. charged for services that you did not receive,

2. billed more than one time for the same service,

3. billed for one type of service, but gave you another (such as charging for one type of equipment but delivering another less expensive type), and or

4. misrepresented information, (such as changing your diagnosis or changing the dates that you were seen in the office),

please call the Provider/Practitioner and ask for an explanation. There may be an error.

If you are unable to resolve the issue, or if you suspect any other suspicious activity, please contact PHP at **(505) 923-5959** or toll-free at **1-800-239-3147**.

Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or Benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. PHP may terminate a Member for any type of fraudulent activity. Some examples of fraudulent activity are:

1. Falsifying enrollment information.

2. Allowing someone else to use your ID Card.

3. Forging or selling prescriptions.

4. Misrepresenting a medical condition in order to receive benefits to which you would not normally be entitled.

By preventing fraud and abuse, PHP can focus on improving the health of individuals, families and communities.

## IV. BENEFITS

***Your particular benefit plan offers Coverage for a wide range of healthcare services. This section gives you the details about your benefits for these services.***

**COVERED BENEFITS ARE SUBJECT TO:**

**1. THE EXCLUSIONS IDENTIFIED IN THIS SECTION AS WELL AS IN SECTION VII. (EXCLUSIONS),**

**2. THE BENEFIT CERTIFICATION REQUIREMENTS OF SECTION V. (BENEFIT CERTIFICATION), AND**

**3. THE LIMITATIONS IDENTIFIED IN SECTION VI. (LIMITATIONS).**

**4. THE DEDUCTIBLE AND/OR COPAYMENT REQUIREMENTS LISTED IN THE SCHEDULE OF BENEFITS.**

**PLEASE REVIEW THESE SECTIONS FOR A COMPLETE UNDERSTANDING OF YOUR BENEFITS.**

### A. Accidental Injury/Urgent Care/Emergency Health Care/Observation/Trauma Services

1. **Urgent Care** means Medically Necessary medical or surgical procedures, treatments, or healthcare services received in an Urgent Care facility or other Provider/Practitioner's office for a condition that is not life-threatening, but requires prompt medical attention to prevent a serious deterioration in a Member's health.

   Members are encouraged to contact their Primary Care Physicians for an appointment, if available, before seeking care from another Provider/Practitioner.

   Follow-up care by a Non-Participating Provider/Practitioner must be Certified by Presbyterian Health Plan (PHP). **The Member will be responsible for charges not Covered by PHP.**

   If a Member believes the condition to be treated is life threatening, he/she should seek Emergency Health Services as outlined below.

2. **Emergency Health Services**

   a. This Agreement Covers acute Emergency Health Services 24 hours per day, seven days per week, when those services are needed immediately to prevent jeopardy to a Member's health. If the Member cannot reasonably access a participating facility, PHP will make arrangements to Cover the care at a Non-Participating facility.

b. Coverage for trauma services and all other Emergency Health Services will continue at least until the Member is medically stable, does not require critical care, and can be safely transferred to a participating facility based on the judgement of the attending Physician in consultation with PHP and in accordance with federal law.

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

d. In determining whether the Member acted as a "reasonable layperson" as described in item b. above, PHP will consider the following factors:

(1) a reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment;

(2) the time of day the care was provided;

(3) the presenting symptoms;

(4) any circumstance that prevented the Member from using PHP's established procedures for obtaining Emergency Health Services.

e. PHP will not deny a claim for Emergency Health Services when the Member was referred to the emergency room by his or her PCP or by PHP.

f. Benefit Certification is not required for Emergency Health Services.

g. If a Member's Emergency Health Services results in a hospitalization directly from the emergency room, the Member is responsible for paying the Inpatient Hospital Copayment rather than the emergency room visit Copayment.

h. For emergencies in PHP's Service Area, the Member should seek medical treatment from Participating Providers/Practitioners whenever possible.

i. Appropriate Out-of-Network Emergency Health Services will be provided to the Member without additional cost. Whether Out-of-Network Emergency Health Services is appropriate, will be determined by the "reasonable layperson" standard in item b. and c. above.

j. Follow-up care from Non-Participating Providers/Practitioners requires a Benefit Certification from PHP.

k. For emergencies outside PHP's Service Area, the Member may seek Emergency Health Services from the nearest appropriate facility where emergency medical treatment can be rendered. **Non-emergent follow-up care outside of PHP's**

**Service Area is not Covered** unless transfer to a Participating Provider/Practitioner would be medically inappropriate and a risk to the Member's health. In such circumstances the services must be Certified by PHP. **Non-emergent follow-up care outside of PHP's Service Area is not Covered** for the convenience or preference of the Member. **The Member is responsible for any such charges that are not Certified by PHP**.

l. All Emergency Health Services, Urgent Care, and trauma care services, whether provided within or outside of PHP's Service Area, are subject to the **Limitations listed in Section VI. (Limitations)** and the **Exclusions listed in Section VII. (Exclusions)** of this Agreement.

3. **Observation Services**

Observation Services are defined as outpatient services furnished by a Hospital and Provider/Practitioner on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Providers/Practitioners written order. To transition from observation to an Inpatient admission, level of care criteria used by PHP must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

## B. Ambulance Services

The following types of Ambulance Services are Covered: (1) Emergency Ambulance Services, (2) High-Risk Ambulance Services, and (3) Inter-Facility Transfer Services.

1. Emergency Ambulance Services are defined as ground or air Ambulance Services delivered to a Member who requires Emergency Health Services under circumstances that would lead a reasonable layperson acting in good faith to believe that transportation in any other vehicle would endanger the patient's health. **Emergency Ambulance Services are Covered only under the following circumstances:**

   a. Within PHP's Service Area, to the nearest participating facility where emergency medical treatment can be rendered, or to a Non-Participating facility if a participating facility is not reasonably accessible. Such services must be provided by a licensed Ambulance Service in a vehicle, which is equipped and staffed, with life-sustaining equipment and personnel.

   b. Outside PHP's Service Area, to the nearest appropriate facility where emergency medical treatment can be rendered. Such services must be provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.

c. PHP will not pay more for air ambulance transportation than it would have paid for transportation over the same distance by ground transportation services, unless the Member's condition renders the utilization of such ground transportation services medically inappropriate.

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

e. In determining whether the Member "acted in good faith" as a "reasonable layperson" when obtaining emergency Ambulance Services, PHP will take the following factors into consideration:

(1) whether the Member required Emergency Health Services, as defined above;

(2) the presenting symptoms;

(3) whether a layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered the Member's health;

(4) whether the Member was advised to seek an ambulance by his/her Primary Care Physician or by PHP. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Agreement.

2. **High-Risk Ambulance Services** are defined as Ambulance Services that are:

a. non-emergency; and

b. Medically Necessary for transporting a high-risk patient; and

c. prescribed by the Member's Physician.

Coverage for **High-Risk Ambulance Services is limited to**:

a. **Air Ambulance Service** when Medically Necessary. However, PHP will not pay more for air ambulance transportation than it would have paid for transportation over the same distance by ground transportation services, unless the Member's condition renders the utilization of such ground transportation services medically inappropriate.

b. **Maternity/Neonatal Ambulance Services,** including ground or air ambulance transportation to the nearest Tertiary Care Facility

(1) for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant; or

(2) when necessary to protect the life of a newly born child.

c. **Ground or air Ambulance Services to any Level I or II** or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

3. **Inter-Facility Transfer Services** are defined as ground or air ambulance transportation between any of the following: Hospitals, Skilled Nursing Facilities or diagnostic facilities. **Inter-facility transfer services are Covered only if they are**:

a. Medically Necessary;

b. prescribed by the Member's Physician; and

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

## C. Cancer Clinical Trials

Routine patient care costs that are incurred as a result of participation in a phase II, III or IV Cancer Clinical Trial in New Mexico are Covered.

1. Routine patient care costs mean:

a. medical services or treatment that is a benefit under this health plan that would be Covered if the patient were receiving standard cancer treatment; or

b. a drug provided to a patient during a Cancer Clinical Trial if the drug has been approved by the Federal Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug.

2. Routine patient care costs are Covered for Members in a phase II, III, or IV Cancer Clinical Trial if:

a. The Clinical Trial Test is undertaken for the purposes of the prevention of reoccurrence, early detection, or treatment of cancer for which no equally or more effective standard cancer treatment exists.

b. The Clinical Trial Test is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.

c. The Clinical Trial Test is being provided in New Mexico as part of a scientific study of a new therapy or intervention.

d. There is no non-Investigational treatment equivalent to the Clinical Trial Tests.

e. There is a reasonable expectation shown in clinical or pre-clinical data that the Clinical Trial Test will be at least as efficacious as any non-investigational alternative.

3. The Clinical Trial Test must be conducted with the approval of a federal organization such as National Institutes of Health or the FDA.

4. If services are not available from a Participating Provider/Practitioner, PHP will Cover services of a Non-Participating Provider/Practitioner only if the Provider/Practitioner agrees to accept PHP's normal reimbursement for similar services, and services are provided in New Mexico.

5. Any care related to the Clinical Trial Test that is investigational requires Benefit Certification by PHP. Those medical services that are not investigational such as lab and x-ray services would require Benefit Certification as identified in Section V. (Benefit Certification) of this Agreement.

6. **Exclusions:**

**In addition to the exclusions listed in Section VII. (Exclusions) of this Agreement, the following are not Covered**:

a. Any Cancer Clinical Trials provided outside of New Mexico as well as, those that do not meet the requirements indicated in items 1-5 above.

b. Costs of the Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

c. Services from Non-Participating Providers/Practitioners, unless services from a Participating Provider/Practitioner are not available. Any Non-Participating services must be Certified by PHP and provided for in New Mexico.

d. The cost of a non-FDA-approved investigational drug, device or procedure.

e. The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Cancer Clinical Trial.

f. Cost associated with managing the research that is associated with the Cancer Clinical Trial.

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

h. Cost of tests that are necessary for the research of the Clinical Trial.

i. Costs paid or not charged for by the Cancer Clinical Trial Providers.

## D. Clinical Preventive Services

Coverage is provided for the following preventive services when performed by or under the direction of the Member's Primary Care Physician at an age and frequency as determined by the Member's healthcare Provider/Practitioner:

1. Preventive Physical Examinations including:

    a. health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sport, school or camp activities;

    b. periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level; and

    c. periodic stool examination for the presence of blood for all persons 40 years of age or older.

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

2. Well Child Care in accordance with the recommendations of the American Academy of Pediatrics.

3. Vision and Hearing Screening performed only by the PCP to determine the need for vision and hearing correction. This does not include routine eye exams or Eye Refractions performed by eye care specialists. One Eye Refraction per Calendar Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases. **Hearing aids and the evaluation for the fitting of hearing aids is not Covered**.

4. Adult and Child Immunizations (shots or vaccines), in accordance with the recommendations of the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, or the U.S. Preventive Services Task Force. Meningococcal vaccine is Covered for freshmen living in college dormitories. **Immunizations for the purpose of foreign travel are not Covered**.

5. Colorectal cancer screening including:

    a. Fecal occult blood testing (FOBT),

    b. Periodic left-side colon examination of 35 to 60 centimeters (Flexible Sigmoidoscopy),

    c. Colonoscopy,

    d. Double contrast barium enema.

6. Periodic glaucoma eye test.

7. Health Education materials and consultation from Providers/Practitioners to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members under 19 years of age, this includes (as deemed appropriate by the Member's Primary Care Physician or as requested by the parents or legal guardian) education information on alcohol and Substance Abuse, sexually-transmitted diseases, and contraception. For Members 19 years of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.

8. Smoking Cessation. For information regarding Smoking Cessation Programs refer to item X. (Smoking Cessation Programs) of this section.

9. Mammography Coverage for low-dose screening mammograms for determining the presence of breast cancer. Coverage includes, but is not limited to, one baseline mammogram to persons age 35 through 39, one mammogram biennially to persons age 40-49 and one mammogram annually to persons age 50 and over.

10. Cytologic Screening (PAP smear screening) and Human Papillomavirus (HPV) screening to determine the presence of precancerous or cancerous conditions and other health problems. Coverage includes, but is not limited to, women who are 18 years of age or older and for women who are at risk of cancer or other health conditions that can be identified through Cytologic Screening.

## E. Complementary Therapies

The only alternative/complementary therapies that are Covered are those that are identified in this Agreement.

1. **Acupuncture (Limited)**

Acupuncture services are available **subject to the following limitations**:

a. Acupuncture is specifically limited to treatment by means of inserting needles into the body to reduce pain, induce anesthesia or for Smoking Cessation treatment. It may also be used for other diagnoses as determined appropriate by the Provider/Practitioner.

b. It is recommended that Acupuncture be part of a coordinated plan of care approved by the Primary Care Physician.

c. **The total combined benefit for Acupuncture services shall not exceed 20 sessions per Member, per Calendar Year.**

2. **Chiropractic Services (Limited)**

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

a. The Provider/Practitioner determines in advance that chiropractic treatment can be expected to result in Significant Improvement in the Member's condition within a period of two months.

b. Chiropractic treatment is specifically limited to treatment by means of manual manipulation, i.e., by use of hands, and other methods of treatment approved by PHP including, but not limited to, ultrasound therapy.

c. Subluxation must be documented by chiropractic examination and documented in the chiropractic record. Radiologic (x-ray) demonstration of Subluxation is not a requirement of PHP for chiropractic treatment.

d. **Chiropractic x-rays are only Covered** when performed by a chiropractor for the following clinical situations, unless clinically relevant x-rays already exist:

(1) acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents;

(2) clinical evidence of significant osteoporosis: recent fracture of the spine, wrist or hip; loss of height over ½ inch, or spine curvature consistent with osteoporotic fractures; or

(3) abnormal neurologic or orthopedic findings suggesting spinal nerve impingement.

e. **Treatment of conditions, other than headache, which do not have acute Subluxation demonstrable on exam are not Covered**, including chronic Subluxation of rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/conditions as determined by PHP as not meeting this definition.

f. **No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is Covered except as specified in this Agreement.**

g. **Treatment provided beyond the point at which the Member is no longer making Significant Improvement will not be Covered**.

h. **The annual benefit for chiropractic therapy is limited in total to 18 sessions.**

3. **Biofeedback (Limited)**

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

4. **Hypnotherapy (Limited)**

Hypnotherapy is **only Covered** when performed by an anesthesiologist or psychiatrist trained in the use of hypnosis when:

a. used within two weeks prior to surgery for chronic pain management; or

b. for chronic pain management when part of a coordinated treatment plan.

5. **Massage Therapy (Limited)**

Massage Therapy is **only Covered** when provided by a licensed physical therapist and as part of a prescribed short-term physical therapy program. See Section IV. (Benefits) item V. (Rehabilitation and Therapy).

**F. Dental Services Including Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)**

Dental services will be provided only in connection with the following conditions when deemed Medically Necessary except in an emergency situation as described in Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation/Trauma Services).

1. Accidental Injury to sound natural teeth, jawbones or surrounding tissue. Accidental Injury treatment is limited to services received within 36 months of the date of the accident. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury.**

2. The correction of a non-dental physiological condition such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.

3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

4. The Surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) are subject to the same conditions, limitations, and Benefit Certification procedures as are applicable to treatment of any other joint in the body. **Orthodontic appliances and treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are specifically excluded, unless the disorder is trauma-related. Services related to Malocclusion treatment, if part of routine dental care and orthodontics, are not Covered.**

5. **Hospitalization, day surgery, outpatient services and/or anesthesia for Non-Covered dental services are not Covered**, unless the patient has a non-dental physical condition that makes hospitalization or anesthesia Medically Necessary and the need for such services has been approved in consultation with PHP.

6. Oral surgery Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
7. Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.

8. **Dental implants are not Covered**.

## G. Diabetes Services

1. In accordance with requirements as defined under NMSA §59A-22-41, this Agreement provides Coverage for individuals with insulin dependent (Type I) diabetes, non-insulin dependent (Type II) diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). PHP will guarantee Coverage for the equipment appliances, Prescription Drug, insulin or supplies that meet food and drug administration approval, and are the medically accepted standards for diabetes treatment, supplies and education.

2. **Diabetes Education.** The following benefits are available from an **approved diabetes educational Provider/Practitioner :**

    a. **Diabetes self-management training, limited to**:

        (1) Medically Necessary visits upon the diagnosis of diabetes;

        (2) visits following a Physician diagnosis that represents a significant change in condition or symptoms requiring changes in the patient's self-management; and

        (3) visits when re-education or refresher training is prescribed by a healthcare Provider/Practitioner with prescribing authority.

    b. Medical nutrition therapy related to diabetes management.

    Approved diabetes educational Providers/Practitioners must be members of the PHP Participating Provider/Practitioner network who are certified, registered or licensed healthcare professionals with recent education in diabetes management.

3. **Diabetes Supplies and Services.** When prescribed by the Member's Physician the following equipment, supplies, appliances, and services are Covered for Members with diabetes. These items must be purchased at a Participating Pharmacy or Durable Medical Equipment (DME) supplier.

    a. Prescriptive diabetic oral agents for controlling blood sugar levels.

b. Medically Necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment, when Certified by PHP.

c. Glucagon emergency kits.

The following items (d. through l.) require use of PHP approved brands and must be purchased at a Participating Pharmacy or Durable Medical Equipment (DME) supplier. Please contact Member Services at **(505) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD for the hearing impaired at **(505) 923-5699** or toll-free at **1-877-298-7407** or at our website at www.phs.org for further information.

d. Blood glucose monitors/meters (Durable Medical Equipment), approved by PHP.

e. Specialized monitors/meters for the legally blind when Certified by PHP.

f. Test strips for blood glucose monitors.

g. Visual reading urine and ketone strips.

h. Lancets and lancet devices.

i. Insulin.

j. Injection aids, including those adaptable to meet the needs of the legally blind.

k. Syringes.

l. Insulin pumps when Medically Necessary, prescribed by a participating endocrinologist, and Certified by PHP.

## H. Diagnostic Services (Tests performed to determine if you have a medical problem)

Coverage is provided for Diagnostic Services, when Medically Necessary and subject to the limitations in Section VI. (Limitations), the exclusions in Section VII. (Exclusions) and the Benefit Certification requirements in Section V. (Benefit Certification) of this Agreement. All Diagnostic Services must be provided under the direction of the Member's Physician. Examples of Covered procedures include, but are not limited to, the following:

1. cardiac procedures including, but not limited to, EKG, EEG, echocardiograms and MUGA scans;

2. clinical laboratory tests;

3. CT Scans;

4. endoscopy procedures;

5. gastrointestinal lab procedures;

6. Magnetic Resonance Imaging (MRI) tests;

7. pulmonary function tests;

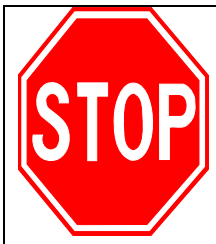
8. radiology/x-ray services;

9. ultrasound procedures;

10. sleep disorder studies;

11. bone density studies.

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




**All plans include limited Coverage for Durable Medical Equipment as indicated in Section IV. (Benefits) item G. (Diabetes Services) item I.6 (Durable Medical Equipment – Eye Refractions, Eyeglasses and Contact Lenses) and item Z.8 (Women's Healthcare – Mastectomy, Prosthetic Devices and Reconstructive Surgery). Additional Durable Medical Equipment may not be Covered. Refer to the Durable Medical Equipment Section of your Schedule of Benefits to determine if you have limited Coverage.**

1. **Durable Medical Equipment (if listed as Covered in your Schedule of Benefits)**

Durable Medical Equipment is equipment that is Medically Necessary for treatment of an illness or Accidental Injury or to prevent the patient's further deterioration. This equipment is designed for repeated use, and includes items such as oxygen equipment, wheelchairs, and crutches. Rental, or at the option of PHP, the purchase of Durable Medical Equipment is Covered when required for therapeutic use, determined to be Medically Necessary by the Member's Physician and if Certified by PHP. **Only Durable Medical Equipment considered standard and/or basic items are Covered.**

**Exclusions:**

a. Upgraded or deluxe items.

b. Items considered "for convenience". A convenience item is an appliance, device, object or service that is for comfort and ease and is not primarily medical in nature. Examples include but are not limited to:

(1) Shower stools/chairs/seats,

(2) Bath grab bars,

(3) Shower heads,

(4) Vaporizers,

(5) Wheelchair/walker/stroller accessories such as baskets, trays, seats or shades.

c. Duplicate DME items (i.e. for home and for office).

d. Home sleep studies.

2. **Orthotic Appliances**

Orthotic Appliances include prefabricated braces and other external devices used to correct a body function including clubfoot deformity. Benefits will be provided if determined to be Medically Necessary by the Member's Physician and if Certified by PHP. **Foot orthotics or shoe appliances are not Covered**, except for Member's with diabetic neuropathy or other significant neuropathy. Custom fabricated knee-ankle-foot orthosis (AFO and/or KAFO) are Covered for Members up to eight years old.

3. **Prosthetic Devices**

Prosthetic Devices are artificial devices, which replace or augment a missing or impaired part of the body. The Purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity are Covered when they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth necessitates replacement. Prosthetic Devices will be provided when determined to be Medically Necessary by the Member's Physician and when Certified by PHP.

Examples of Prosthetic Devices include, but are not limited to, breast prostheses when required as a result of mastectomy, artificial limbs, prosthetic eye, prosthodontic appliance, penile prosthesis, joint replacements, heart pacemakers, tracheostomy tubes and cochlear implants. **Dental implants are not Covered**.

4. **Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices**

a. Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices is Covered when Certified by PHP and when Medically Necessary due to change in the Member's condition, wear or after the product's normal life expectancy has been reached.

b. **Exclusions:**

(1) Repair and replacement due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience.

(2) Repair and replacement of items under the manufacturer or supplier's warranty.

(3) If the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair, **additional wheelchair(s) are not Covered**. One-month rental of a wheelchair is Covered if a Member owned the wheelchair that is being repaired.

5. **Surgical Dressing**

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

b. Gradient compression stockings are Covered up to two pairs per Calendar Year for:

(1) Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation or;

(2) Venous stasis ulcers that have been treated by a Physician or other healthcare professional requiring Medically Necessary debridement (wound cleaning).

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

d. **Exclusions related to Surgical Dressings:**

(1) Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze (such as 4 by 4's) and ace bandages, except when provided in a Hospital or Physician's office or by a home health professional.

(2) Gloves unless part of a wound treatment kit.

(3) Elastic support hose.

6. **Eye Refractions, Eyeglasses and Contact Lenses (Limited)**

All eyeglasses or contact lenses are subject to the **limitations listed in Section VI. (Limitations) and the exclusions listed in Section VII. (Exclusions)** of this Agreement.

a. Contact lenses are Covered for the correction of aphakia (those with no lens in the eye) or kerataconus. This includes the Eye Refraction examination.

b. One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is Covered within 12 months after cataract surgery or when related to Genetic Inborn Errors of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.

c. **Exclusions relating to Eye Refractions, Eyeglasses and Contact Lenses:**

(1) Except as above, routine vision care, Eye Refractions, corrective eyeglasses, sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof.

(2) Routine vision care and Eye Refractions for determining eyeglass or contact lens prescriptions.

(3) Eye refractive procedures including radial keratotomy, laser procedures, and other techniques**.**

(4) Visual training.

7. **Hearing Aids**

**Hearing aids and the evaluation for the fitting of hearing aids are not Covered.**

## J. Family, Infant and Toddler (FIT) Program

Coverage for children, from birth to age three, for or under the Family, Infant and Toddler Program (FIT) administered by the Department of Health, provided eligibility criteria are met, is provided for Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel in accordance with that which is required under N.M.S.A. § 59A-46-38.1. Benefits used under this section will not be applied to any maximum lifetime or annual plan limits applicable to this plan. This benefit is subject to an annual maximum. Refer to your Schedule of Benefits for the dollar amount maximum.

## K. Genetic Inborn Errors of Metabolism Disorders (IEM)

1. Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism where there are standard methods of treatment, when Medically Necessary and subject to **the limitations listed in Section VI. (Limitations), the exclusions listed in Section VII. (Exclusions)** and the Benefit Certification requirements listed in Section V. (Benefit Certification) of this Agreement. 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 are Covered. Covered services include:

a. nutritional and medical assessment,

b. clinical services,

c. biochemical analysis,

d. medical supplies,

e. Prescription Drugs,

f. corrective lenses for conditions related to Genetic Inborn Errors of Metabolism,

g. nutritional management,

h. Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status when Certified by PHP's pharmacy department.

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

2. **Exclusions:**

a. Food substitutes for lactose intolerance including soy foods or formulas or other Over-the-Counter (OTC) digestive aids, unless listed as a Covered OTC medication on the Preferred Drug Listing.

b. Organic foods,

c. Ordinary foodstuffs that might be part of an exclusionary diet,

d. Food substitutes that do not qualify as Special Medical Foods,

e. Any product that does not require a Physician's prescription,

f. Special Medical Foods for conditions that are not present at birth,

g. Food items purchased at a health food, vitamin or similar store,

h. Foods purchased on the Internet, and

i. Special Medical Foods for conditions including, but not limited to: Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, and Allergies to food products.

3. **Copayments**

Please refer to your Schedule of Benefits for applicable office visit, Inpatient Hospital, outpatient facility, Prescription Drug and other related Copayments.

## L. Home Healthcare Services/Home Intravenous Services and Supplies

Home healthcare services are health services provided to a Member confined to the home due to physical illness. **Private Duty Nursing is not Covered**. Home healthcare services and home intravenous services and supplies will be provided by a Home Health Agency at a Member's home when Certified by PHP and when prescribed by the Member's Physician. Any such prescription or Benefit Certification must be renewed at the end of each 60-day period. PHP will not impose a limitation on the number of related hours per visit.

1. Home healthcare services shall include Medically Necessary skilled intermittent home healthcare services provided by a registered nurse or a licensed practical nurse; physical, occupational, and/or respiratory therapist and/or speech pathologists. Intermittent home health aide services are Covered only when part of an approved plan of care which includes Medically Necessary skilled services. **Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify for home healthcare benefits.** Examples of Custodial Care that are not Covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

2. Medical equipment, drugs and medications, and supplies deemed Medically Necessary by a Participating Physician for the provision of health services in the home, except Durable Medical Equipment.

3. Home healthcare or home intravenous services as an alternative to hospitalization, as determined by the Member's Physician, and as approved by PHP.

4. Total parenteral and enteral nutrition as the sole source of nutrition, when Certified by PHP.

5. Specialty Pharmaceuticals as described in Section IV. (Benefits) item S. (Covered Medications) when provided by a Home Health Agency, and when Certified by PHP. Refer to the Schedule of Benefits for the required Copayment for Specialty Pharmaceuticals.

## M. Hospice Care (Where a certified Hospice program is available)

1. Inpatient and in-home Hospice services are a Covered Benefit for terminally ill Members when services are provided by a Hospice program approved by PHP during a Hospice benefit period (and not Covered to the extent that they duplicate other Covered services available to the Member). Benefits are provided for a PHP participating Hospice or other facility when approved by the Member's Primary Care Physician and Certified by PHP. The Hospice benefit period must begin while the Member is enrolled in this plan, and Coverage through PHP must be continued throughout the benefit period in order for Hospice benefits to continue.

2. The Hospice benefit period is defined as follows:

   a. beginning on the date the Member's Physician certifies that the Member is terminally ill with a life expectancy of six months or less; and

   b. ending six months after it began, except as described in item c. below, or upon the death of the Member;

   c. if a Member requires an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and the Member's Primary Care Physician must recertify the Member's medical condition to PHP. No more than one additional Hospice benefit period will be Certified by PHP.

3. The following services will be Covered under the Hospice benefit **(where a certified Hospice program is available)**:

   a. Inpatient Hospice care;

   b. Physician visits by participating Hospice Physicians;

   c. home health care by approved home healthcare personnel;

   d. physical therapy;

   e. medical supplies;

   f. drugs and medication for the pain and discomfort specifically related to the terminal illness;

   g. medical transportation; and

   h. respite care for a period not to exceed five continuous days for every 60 days of Hospice care. No more than two respite care stays will be available during a Hospice benefit period.

4. **Hospice benefits are not Covered for the following services:**

   a. food, housing, and delivered meals;

   b. volunteer services;

   c. comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits);

   d. homemaker and housekeeping services;

   e. private duty nursing;

f. pastoral and spiritual counseling; and

g. bereavement counseling.

5. **The following services are not Covered** under Hospice care, but may be Covered elsewhere in this Agreement subject to the Member's Copayment requirements:

a. acute Inpatient Hospital care for curative services;

b. Durable Medical Equipment;

c. Physician visits by other than a participating Hospice Physician; and

d. Ambulance Services.

6. Where there is not a certified Hospice program available, regular home healthcare service benefits will apply. Refer to Section IV. (Benefits) item L. (Home Healthcare Services/Home Intravenous Services and Supplies) of this Agreement.

**N. Hospital Admissions- Inpatient**

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

Hospital admissions must be Certified by PHP. Hospital services must be provided under the direction of the Member's Physician, unless such services constitute Emergency Health Care Services.

**Inpatient services provided by Non-Participating Provider/Practitioners or facilities are not Covered** except as provided in Section III. (General Information) item F. (Participating and Non-Participating Providers/Practitioners), item K. (Dependent Students), and Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation/
Trauma Services).

Inpatient Hospital services include, but are not limited to, the following when Medically Necessary, subject to the Benefit Certification requirements listed in Section V. (Benefit Certification), the limitations listed in Section VI. (Limitations) and the exclusions listed in Section VII. (Exclusions):

1. Acute medical detoxification: Inpatient treatment for acute medical detoxification induced by alcohol or drug abuse shall be provided when Medically Necessary at an acute care facility or a treatment center specializing in Substance Abuse. **Acute medical detoxification in a Residential Treatment Center is not Covered**. Acute medical detoxification treatment must be Certified by PHP. Acute medical detoxification does not include rehabilitation.

2. Anesthetics, oxygen, and Covered medications.

3. Blood, blood plasma and blood components.

4. Diagnostic Services, as specified in Section IV. (Benefits) item H. (Diagnostic Service).

5. Dressings, casts and special equipment when supplied by the Hospital for use in the Hospital.

6. Facilities: use of operating, delivery, recovery and treatment rooms and equipment and all other facilities.

7. Meals and special diets or parenteral (intravenous) nutrition.

8. Physician and surgeon services.

9. Private room and board accommodations when Medically Necessary and Certified by PHP.

10. Semi-Private room and board accommodations, including general duty nursing care.

11. Special services and procedures, such as special duty nursing, when Certified by PHP.

12. Surgery, when Certified by PHP. **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.

13. Therapeutic and support care, services, supplies, appliances, and therapies including care in specialized intensive and coronary care units, radiation therapy and inhalation therapy.

## O. Mental Health and Alcoholism and Substance Abuse

### 1. Mental Health Services

To receive services relating to mental health Members may call the PHP Behavioral Health Department directly at **(505) 923-5470** or toll-free at **1-800-453-4347** or self-refer to a Participating Behavioral Health Provider/Practitioner. The Behavioral Health Provider/Practitioner will be responsible for any additional Benefit Certification.

a. Acute Inpatient mental health services will be Covered when performed by a Participating Provider/Practitioner and when Certified by PHP. Coverage is provided for Inpatient mental health and partial hospitalization.

b. Partial hospitalization can be substituted for the Inpatient mental health services when Certified by PHP's Behavioral Health Department. Partial hospitalization is a non-residential, Hospital-based day program that includes various daily and weekly therapies. The Copayment will be waived if the partial hospitalization immediately (within 24 hours or the next business day) follows an Inpatient Hospital discharge.

c. Outpatient, non-Hospital based, evaluative and therapeutic mental health services are provided when deemed Medically Necessary and Certified by the PHP Behavioral Health Department.

d. Acute medical detoxification benefits are Covered under Inpatient and Outpatient Medical Services found in Section IV. (Benefits) item N. (Hospital Admissions–Inpatient) and item Q. (Outpatient Medical Services) of this Agreement.

e. **Exclusions:**

**In addition to the exclusions listed in Section VII. (Exclusions) of this Agreement, the following are not Covered**:

(1) Co-dependency treatment;

(2) Counseling: sex, pastoral/spiritual, and bereavement counseling;

(3) psychological testing when not Medically Necessary;

(4) special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or behavioral problems. This applies whether or not associated with manifest mental illness or other disturbances;

(5) Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy;

(6) Alcohol and/or Substance Abuse are not considered behavioral health benefits.

2. **Alcoholism Services and Substance Abuse Services**

Unless listed as Covered in your Schedule of Benefits or unless your employer qualifies for and has purchased the Optional Benefit Rider, the only Alcoholism services Covered under this Agreement are for acute medical detoxification services as listed in Section IV. (Benefits) item N. (Hospital Admissions–Inpatient) and Q. (Outpatient Medical Services) of this Agreement.


**Large Group Plans – Alcohol and Substance Abuse Rehabilitation Services are only Covered if** your Employer Group has purchased the optional Alcoholism/Substance Abuse. Please check the Optional Benefit Riders included with this Agreement to determine if you have Coverage and for the applicable Copayment amount for these services.

**Small Group Plans - Alcohol and Substance Abuse Rehabilitation Services may not be Covered.** Refer to your Schedule of Benefits to determine if you have Coverage and for the applicable Copayment .

Refer to your Schedule of Benefits to determine if you are on a large Group or small Group plan.

**If listed as Covered in the Schedule of Benefits or Optional Benefit Rider:**

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

a. To obtain Alcoholism/Substance Abuse services, Members may contact the PHP Behavioral Department at (505) 923-5470 or toll-free at 1-800-453-4347 or self refer to a Participating Behavioral Health Provider/Practitioner. The Behavioral Health Provider/Practitioner will be responsible for any additional Benefit Certification.

b. **Benefits for Alcoholism/Substance Abuse treatment are limited to one episode of treatment per Calendar Year, subject to a Lifetime Maximum per Member of three separate episodes of treatment.** An episode of treatment is a planned, structured, and organized program to promote an alcohol and/or Substance Abuse free status that may include different facilities or modalities including Inpatient, partial hospitalization and outpatient services.

c. **The following limitations apply to an episode of treatment:**

(1) Inpatient treatment in a Hospital or Substance Abuse treatment center will be Covered when Certified by PHP's Behavioral Health Department. **Coverage will be provided for up to 30 days per Member per Calendar Year.**

(2) Partial hospitalization can be substituted for Inpatient Alcoholism or Substance Abuse services if Certified by PHP. Partial hospitalization is a non-residential day program, attended by the patient at least eight hours a day, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days shall be the equivalent of one day of Inpatient care.

(3) **NOTE: COVERAGE FOR ANY COMBINATION OF INPATIENT AND PARTIAL HOSPITALIZATION BENEFITS IS LIMITED TO THE EQUIVALENT OF 30 INPATIENT DAYS PER MEMBER, PER CALENDAR YEAR.**

(4) Intensive and standard outpatient evaluative and therapeutic services for Alcoholism and Substance Abuse will be provided if Certified by PHP's Behavioral Health Department. The combined Coverage for all outpatient evaluative and therapeutic **Alcohol and Substance Abuse services (both intensive and standard) is limited to 20 visits per Member per Calendar Year**. Intensive outpatient Alcohol and/or Substance Abuse services are defined as visits lasting three hours per visit and attended by the Member three times per week. Standard outpatient therapy visits are defined as outpatient visits last up to 50 minutes.

(5) An episode of treatment will be considered complete if any one of the following occurs:

(a) the Member is discharged on medical advice from Inpatient treatment, partial hospitalization and/or outpatient services; or

(b) the Member has reached the annual maximum benefit for Alcoholism or Substance Abuse Services; or

(c) the Member fails to materially comply with any treatment program for a period of 30 days.

No further benefits for Alcoholism or Substance Abuse will be available under this Agreement after benefits have been provided for three episodes of treatment.

d. Acute medical detoxification Benefits are Covered under Inpatient and Outpatient Hospital Services found in Section IV. (Benefits) item N. (Hospital Admissions – Inpatient) and item Q. (Outpatient Medical Services).

e. **Exclusions:**

**In addition to the exclusions listed in the Group Subscriber Agreement, the following are not Covered**:

(1) treatment in a halfway house;

(2) Residential Treatment Centers used for the treatment of any condition other than Alcoholism and/or Substance Abuse and only when the optional Substance Abuse Rider has been purchased;

(3) Co-dependency treatment; sex, pastoral/spiritual, and bereavement counseling;

(4) court mandated treatment, or treatment that is a condition of parole or probation or in lieu of sentencing; and

(5) any treatment for Alcoholism/Substance Abuse services after the maximum episodes of treatment allowed under this Agreement have been completed.

**P. Nutritional Support and Nutritional Supplements**

1. Prenatal Nutritional Supplements when prescribed by a practitioner are Covered for pregnant women.

2. If there is a pharmacy benefit, nutritional supplements that require a prescription to be dispensed are Covered when prescribed by a practitioner and when Medically Necessary to replace a specific documented deficiency.

3. B-12 injections administered at the practitioner's office are Covered when there is a B-12 insufficiency and when medically appropriate to treat pernicious anemia and other associated diseases. **B-12 is not Covered for fatigue.**

4. Other nutritional supplements administered by injection at the practitioner's office are Covered when Medically Necessary.

5. Enteral formulas or products, as Nutritional Support, are Covered only when prescribed by a practitioner and administered by enteral tube feedings. **Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system are not Covered**.

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

7. Special Medical Foods as listed as Covered in item K. (Genetic Inborn Errors of Metabolism (IEM)) of this Section.

**Q. Outpatient Medical Services** (Services administered at a medical facility such as a Hospital or doctor's office after which the Member goes home without being admitted to the facility).

Outpatient medical services include reasonable Hospital services provided on an ambulatory basis, and those preventive, Medically Necessary, and diagnostic and treatment procedures that are prescribed by the Member's Primary Care or Attending Physician, subject to the Benefit Certification requirements listed in Section V. (Benefit Certification), the limitations listed in Section VI. (Limitations) and the exclusions listed in Section VII. (Exclusions) of this Agreement. Such services may be provided in a Hospital, Physician's office, any other appropriate licensed facility, or any other appropriate facility if the professional delivering the service is licensed to practice, is certified, and is practicing as authorized by applicable law or authority, a medical group, an independent practice association or other authority authorized by applicable New Mexico Law. **Outpatient services provided by Non-Participating Providers/Practitioners are**

**not Covered** except as provided in Section III. (General Information) item F. (Participating and Non-Participating Providers/Practitioners), item K. (Dependent Students), and Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation/Trauma Services).

1. **Anesthetics**, oxygen, drugs, medications.

2. **Blood,** blood plasma and blood components.

3. **Chemo** and **radiation** therapy.

4. **Diagnostic Service**s, as specified in Section IV. (Benefits) item H. (Diagnostic Services).

5. **Dressings, casts** and special equipment when supplied by the Hospital for use in the Hospital.

6. **Facilities:** use of operating, recovery and treatment rooms and equipment.

7. **Acute Medical detoxification**: Medically Necessary services for Substance Abuse medical detoxification.

8. **Observation:** Observation Services are defined as outpatient services furnished by a Hospital and Provider/Practitioner on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Providers/Practitioners written order. To transition from observation to an Inpatient admission level of care criteria used by PHP must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

9. **Sleep disorder studies.**

10. **Surgeries**, including use of operating, delivery, recovery, and treatment rooms, and equipment and supplies, including anesthesia, dressings and medications.

11. **Therapeutic and support care** services, supplies, appliances, and therapies.

**R. Physician Services**

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

1. a licensed Physician,

2. specialist and services provided by other health professionals who are licensed to practice, are certified, and are practicing under the authority of PHP,

3. a medical group,

4. an independent practice association, or

5. other authority authorized by applicable New Mexico Law.

The Physician services**,** Covered by this Section are subject to the Benefit Certification requirements listed in Section V. (Benefit Certification), the limitations listed in Section VI. (Limitations) and the exclusions listed in Section VII. (Exclusions) of this Agreement. This Agreement Covers consultation, healthcare services and supplies provided by the Member's Participating Provider/Practitioner, including:

1. Office visits provided by the Member's Physician. Services of a Physician for the diagnosis and treatment for mental illness or Substance Abuse shall be provided according to Section IV. (Benefits) item O. (Mental Health and Alcoholism and Substance Abuse).

   **"Telephone visits and electronic mail (E-mail)" by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient is not Covered. Also "get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided is not Covered.**

2. Home Visits, if Medically Necessary.

3. Outpatient surgery and Inpatient surgery including necessary anesthesia services by a qualified Participating Provider/Practitioner. Hospital and skilled nursing home visits by Participating Physicians as part of continued supervision of Covered care.

4. Hospital and skilled nursing home visits by Participating Physicians as part of continued supervision of Covered care.

5. Allergy Immunotherapy, including testing and sera. Only when the Prescription Drug Benefits are listed as Covered in your Schedule of Benefits or Optional Prescription Drug Rider.

6. FDA approved injections in accordance with accepted medical practice, except those specifically limited and/or excluded in Section IV. (Benefits) item S. (Covered Medications) and item T. (Prescription Drug Benefits – (Outpatient (4-Tier))

7. Family planning/Infertility services:

   a. FDA approved contraceptive devices and prescription drugs excluding Over-the-Counter OTC) items, unless listed as a Covered OTC medication on the Preferred Drug Listing, and investigational devices/medications.

   b. Sterilization procedures. **Reversals of voluntary sterilization are not Covered**.

c. Infertility diagnosis and treatment, including drugs and injections administered in the Physician's office and approved by PHP in accordance with accepted medical practice for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery. **Artificial insemination is Covered for up to three inseminations. Donor sperm is not Covered**. **In-vitro, GIFT and ZIFT fertilization are not Covered. Reversal of voluntary sterilization is not Covered**.

d. Elective abortions as identified in item Z. (Women's Healthcare) of this Section.

7. **Student Health Centers**: Dependent Students attending school either in the PHP Service Area or outside of the PHP Service Area may receive care through their Primary Care Physician or at the Student Health Center. A Benefit Certification from PHP is not needed prior to receiving care from the Student Health Center. Services provided outside of the Student Health Center are limited to Medically Necessary Covered services for the initial care or treatment of an Emergency Health Service or Urgent Care situation.

8. **Second medical opinions** by a participating specialist or Primary Care Physician (PCP). The office visit Copayment will not apply if PHP requires a second opinion to evaluate the medical appropriateness of a diagnosis or service. The office visit Copayment will apply when the Member or the Provider/Practitioner requests the second opinion.

## S. Covered Medications

1. **The following drugs are Covered when purchased through a Participating Pharmacy or Participating Provider/Practitioner and prescribed by a Participating Physician:**

a. Medically Necessary nutritional supplements for prenatal care when prescribed by the attending Physician. Refer to your Schedule of Benefits for the Copayment amount.

b. Insulin and diabetic oral agents for controlling blood sugar levels. Refer to your Schedule of Benefits for the Copayment amounts.

c. Immunosuppressive Drugs following transplant surgery. Refer to your Schedule of Benefits for the Copayment amount.

d. Specialty Pharmaceuticals (Injectable forms). When administered in the Physician's office, by home IV service, or in any other outpatient setting. Refer to your Schedule of Benefits for the Copayment amount. Benefit Certification by PHP may be required.

e. Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status when Certified by Presbyterian Health Plan's pharmacy department. Refer to item K. (Genetic Inborn Errors of Metabolism - IEM) of this Section and your Schedule of Benefits for more information, exclusions and Copayment amounts.

f. Smoking Cessation Pharmacotherapy. Prescription Drugs purchased at a Participating Pharmacy **limited to two 90-day courses of treatment per Calendar Year.** Refer to the "Covered Medications" in your Schedule of Benefits for Copayment amounts.

2. **Continuation of therapy using any drug is dependent upon its demonstrable efficacy.**

## T. Prescription Drug Benefit (Outpatient) (4-Tier )


**Large Group Plans – Outpatient Prescription Drugs are only Covered if** your Employer Group has purchased the optional Prescription Drug Rider. The basic plan does, however, include some limited benefits for outpatient Prescription Drugs. Refer to item S. (Covered Medications) above. Please Check the Optional Benefit Riders included with this Agreement to determine if you have additional Prescription Drug Coverage and for the applicable Copayment for these services. **If your employer has purchased the 2-Tier Prescription Drug Rider all language in the 2-Tier Prescription Drug Rider supercedes the language in this section.**

**Small Group Plans – Outpatient Prescription Drugs may not be Covered**. The basic plan does, however, include some limited benefits for outpatient Prescription Drugs. Refer to item S. (Covered Medications) above. Refer to your Schedule of Benefits to determine if you have additional Prescription Drug Coverage and for the applicable Copayment amount for these services.

Your Schedule of Benefits will indicate if you are on a large Group or small Group plan.

**If outpatient Prescription Drugs are listed as Covered in your Schedule of Benefits or if the 4-Tier Prescription Drug Rider has been purchased, the following Benefits and limitations apply:**

1. **Outpatient Prescription Drugs,** including FDA approved contraceptives and devices, are a Covered Benefit only when obtained from a Participating Pharmacy and when prescribed by the Participating Physician for a medically appropriate use.

   For each Prescription Drug purchased at a PHP Participating Pharmacy, one applicable generic (Preferred), brand (Preferred) or Non-Preferred Copayment will be required for a 30-day supply up to the maximum dosing recommended by the manufacturer. When available, FDA approved generic drugs will be dispensed regardless of the brand name indicated. If the Member or Physician requests the brand name in place of the generic, the Member will be responsible for payment of the generic Copayment plus the difference in the cost (if any) between the generic and brand drug.

   The appropriate generic (Preferred), brand (Preferred) or Non-Preferred Copayment required for each type of prescription or refill is as follows:

   a. Tablets/Capsules, Packets: one Copayment per 30-day supply up to the maximum dosing recommended by the manufacturer;

b. Liquids: one Copayment per 30-day supply up to the maximum dosing recommended by the manufacturer;

c. Ointments, creams and lotions: one Copayment per 30-day supply 30-day supply up to the maximum dosing recommended by the manufacturer; and

d. Pre-packaged items: one Copayment per pre-packaged item. Examples of pre-packaged items include, but are not limited to:

(1) Diabetic supplies including insulin, insulin syringes, needles, glucose test tapes, acetone test tapes, and Lancets. (Insulin pump supplies, other than insulin, are considered to be Durable Medical Equipment.)

(2) Prescription medications such as asthma inhalers.

(3) Over-The-Counter (OTC) medications if it is a cost-effective option, a prescription is required for approved OTC medications and is subject to the generic (Preferred) copayment. Approved OTC medications are subject to change as determined by PHP's Pharmacy and Therapeutics Committee.

e. Specialty Pharmaceuticals: For Specialty Pharmaceuticals obtained through a designated specialty pharmacy vendor a percentage Copayment up to a maximum of dollar amount per injection/prescription is required, except when administered in an in-patient Hospital setting if Medically Necessary. Refer to your Schedule of Benefits for these percentage and dollar amount limits. These products may require Benefit Certification.

Specialty Pharmaceuticals include, but are not limited to, growth hormones, low molecular weight heparins, interferons, immunologic agents and anti-tumor necrosis factors. A copy of this listing is available on our website at www.phs.org or by calling PHP's Member Services Department at **(505) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD **(505) 923-5699,** TTY/TDD toll-free **(877) 298-7407.**

2. **Continuation of therapy using any drug is dependent upon its demonstrable efficacy.**

3. **Prescription medications/supplies - 90-Day supply at a Participating Pharmacy (voluntary).**

Members have the option to purchase a 90-day supply of Maintenance Medications at a PHP Participating Pharmacy. Under the 90-day at Retail pharmacy benefit, Preferred and Non-Preferred Maintenance Medications can be obtained from a Participating Pharmacy. The Member will be charged one of the three applicable Copayments for a 90-day supply up to the manufacturer's usual maximum recommended dosing for the medication. Copayments are as follows:

| | |
|---|---|
| Generic (Preferred) | 3 x generic Copayment |
| Brand (Preferred) | 3 x brand Copayment |
| Non-Preferred | 3 x Non-Preferred Copayment |

4. **Mail Order Pharmacy**

Members have a choice of obtaining certain maintenance Prescription Drugs directly at Participating Pharmacies or by ordering them through the mail. Under the mail order pharmacy benefit, Preferred and Non-Preferred Maintenance Medications can be obtained through the mail service pharmacy identified in the PHP Provider Directory. Members may purchase a 90-day supply up to the maximum dosing recommended by the manufacturer. Certain drugs may not be purchased by mail order, such as medications on the Specialty Pharmaceutical Listing. Copayments are as follows for mail order:

| | |
|---|---|
| Generic (Preferred) | 2 x generic Copayment |
| Brand (Preferred) | 2.5 x brand Copayment |
| Non-Preferred | 3 x Non-Preferred Copayment |

5. **Over-the-Counter (OTC) Medications**

When a prescription medication is available at an equivalent dose Over-the-Counter (OTC), PHP will cover the OTC version if it is a cost-effective option. **A prescription is required for approved OTC medications and is subject to a Copayment.** The Member must puchase the approved OTC medication directly from a PHP Participating Pharmacy**. If an approved OTC medication is not purchased directly from a pharmacist at a PHP Participating Pharmacy, the OTC medication is not covered**. Approved OTC medications are subject to change as determined by the PHP's Pharmacy and Therapeutics Committee. Refer to the PHP Preferred Drug List for Covered OTC medications.

6. **Tablet-Splitting Program (Voluntary)**

If a medication qualifies for the tablet-splitting program a Member has the option of having the pharmacist cut the higher strength tablet in half. If you participate in the tablet-splitting program your Copayment will be half of your regular Copayment. For example, if your Copayment is $30.00, under the program you would pay only $15.00. Talk with your pharmacist if you wish to take advantage of the tablet-splitting program and they will perform the tablet splitting for you. Medications eligible for this program are subject to change as determined by PHP's Pharmacy and Therapeutics Committee. Refer to the PHP Preferred Drug List to locate approved medications for tablet splitting.

7. **Member Reimbursement for Out-of-Area**

If a medical emergency occurs outside of the PHP Service Area and the Member uses a Participating Pharmacy, the Member will be responsible for payment of the appropriate Copayment. If the Member goes to a Non-Participating Pharmacy, the Member must pay for the prescription and submit a claim form with an itemized receipt to PHP for reimbursement. If approved, the reimbursement will be based on the Reasonable and Customary Charge subject to the applicable Copayment and limited to a 14-day supply per prescription, with no refills allowed. The claim form together with the itemized receipt must contain the following information:

a. patient's name and ID number;

b. name and quantity of the drug;

c. date purchased;

d. name and phone number of Physician;

e. name and phone number of pharmacy;

f. reason for the purchase (nature of emergency); and

g. proof of payment.

8. **Exclusions related to Prescription Drugs:**

a. Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained.

b. Prescriptions ordered by a Non-Participating Provider/Practitioner or purchased at a Non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area.

c. Over-The-Counter medications and drugs for which there is a non-prescription equivalent available with the exception of approved OTC medications as determined by PHP's Pharmacy and Therapeutics Committee. Refer to the PHP Preferred Drug Listing for a list of Covered OTC medications.

d. Compound Prescription Drugs.

e. Replacement prescriptions resulting from loss, theft, or destruction.

f. Prescription Drugs (as listed as Covered in the Schedule of Benefits and this Group Subscriber Agreement) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available.

g. Drugs, medicines, treatments, procedures, or devices that PHP determines are Experimental or Investigational.

h. Disposable medical supplies, except when provided in a Hospital or a Physician's office or by a home health professional.

i. Treatments and medications for the purpose of weight reduction or control except for Medically Necessary treatment for morbid obesity.

j. Nutritional supplements unless for prenatal care as prescribed by the attending Physician or as sole source of nutrition. **Infant formula is not Covered** under any circumstance.

k. Medications used for the treatment of sexual dysfunction.

l. Medications used for cosmetic purposes.

m. New medications for which the determination of criteria for Coverage has not yet been established by PHP's Pharmacy and Therapeutics Committee.

## U. Reconstructive 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, and nasal rhinoplasty.

Cosmetic Surgery from which an improvement in physiological function can reasonably be expected is considered Reconstructive Surgery and will be provided if performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease. Reconstructive Surgery must be prescribed by the Member's Physician and Certified by PHP. For information regarding Reconstructive Surgery following a Mastectomy refer to Z. (Women's Health Care) of this section.

## V. Rehabilitation and Therapy

1. **Cardiac Rehabilitation Services**. Coverage is provided for **12 sessions** of progressive exercises and continuous electrocardiogram (ECG) monitoring and up to **24 sessions** of progressive exercises and intermittent ECG monitoring, per Member per Calendar Year, **when provided at a participating Cardiac Rehabilitation Facility**.

2. **Pulmonary Rehabilitation Services**. Coverage is provided for 24 sessions of progressive exercises and monitoring of pulmonary functions per Member per Calendar Year, **when provided at a participating Pulmonary Rehabilitation Facility.**

3. **Short-Term Rehabilitation Services. Short-Term Rehabilitation** benefits are available for physical therapy and occupational therapy, provided in a participating Rehabilitation Facility, Skilled Nursing Facility, Home Health Agency, or outpatient setting. Short-Term Rehabilitation is designed to assist Members in restoring functions, which were lost or diminished due to a specific episode of illness or injury (for example, stroke, motor vehicle accident, or heart attack). **Coverage is subject to the following limitations:**

   a. Outpatient physical and occupational therapy requires that the Primary Care Physician or other appropriate treating Physician must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in the Member's condition within a period of two months. Treatment goals must be established at the initial visit. These goals must define the expected Significant Improvement. A licensed physical or occupational therapist must provide and/or

direct therapy treatments. Treatments by a physical or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist. **Treatments delivered by athletic trainers are not Covered**.

b. If Certified by PHP, outpatient Short-Term Rehabilitation will be Covered for up to two months from the date that rehabilitation begins. Following the initial two months of treatment, outpatient Short-Term Rehabilitation Services may be extended upon recommendation of the Primary Care Physician and/or other appropriate treating Physician in consultation with PHP, if Medically Necessary and if Certified by PHP.

Extension of Short-Term Outpatient Rehabilitation beyond the initial two months may be Certified for one additional two-month period, for a total of four months. Such services must result in continued Significant Improvement of a Member's physical condition. Expectation of Significant Improvement will be established if the Member meets all therapy goals for the preceding two months as documented in the therapy record. Outpatient rehabilitation beyond four consecutive months would be considered long term and is not Covered.

c. Under this specific PHP benefit plan, **the benefit limitation above is per condition, illness or injury and does not renew at the beginning of a new Calendar Year.**

d. **Long-Term Rehabilitation Services are not Covered**. Therapies are considered long-term when:

(1) the Member has reached maximum rehabilitation potential;

(2) has reached a point where Significant Improvement is unlikely to occur; or

(3) has had therapy for four consecutive months.

Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. **Treatment of chronic conditions is not Covered**. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down's Syndrome, Cerebral Palsy, Autism, and Developmental Delays not associated with a defined event of illness or injury.

e. **Vocational Rehabilitation Services are not Covered**.

4. **Outpatient Speech Therapy.** Speech therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Speech therapy is Covered when provided by a licensed or certified speech therapist subject to the following limitations:

a. The Primary Care Physician or other appropriate treating Physician must determine in advance, in consultation with PHP, that speech therapy can be expected to result in Significant Improvement in the Member's condition within a period of two months.

b. Speech therapy must be Certified by PHP.

c. Following the initial two months of treatment, in-patient or outpatient speech therapy may be extended for a period not to exceed two additional two-month periods when:

(1) Certified by PHP; and

(2) the referring Physician in consultation with PHP certifies that the speech therapy is Medically Necessary and will result in Significant Improvement. For purposes of Certifying speech therapy beyond the initial two months, the determination of Significant Improvement will be established if the Member has met all therapy goals for the preceding two months as documented in the therapy record.

d. In no event will speech therapy be Covered beyond six consecutive months. Any speech therapy beyond six consecutive months is defined as **Long-Term Therapy, which is not Covered** under any circumstances.

e. **Speech therapy will be Covered only for the following conditions:**

(1) When speech or swallowing loss is due to or caused by the following:

(a) cleft palate;

(b) never speaking, (when physical development is normal but the child is mute or speech is not understandable);

(c) speech disorders secondary to brain inflammation or infection;

(d) brain oxygen deprivation (anoxia);

(e) head injury;

(f) facial deformities.

(2) Delayed speech in children will be Covered only for the following:

(a) failure to grow normally with significant language delay under age five;

(b) infants with failure to suck resulting in lack of sufficient oral muscular strength for beginning speech;

(c) children with chronic or recurring otitis media with demonstrable hearing loss;

(d) neurologically impaired children with documented diagnosed disorders of the nervous system.

(3) Myofunctional therapy (tongue thrust) post injury/illness will be Covered in conjunction with speech therapy.

f. **Therapy for stuttering is not Covered**.

g. **Hearing aid evaluations are not Covered**.

h. **No additional benefits are available for speech therapy.**

i. **Under this specific PHP benefit plan, this benefit does not renew at the beginning of a new Calendar Year.**

5. Therapy provided in the Inpatient setting such as, but not limited to, Rehabilitation Facilities, Skilled Nursing Units, Home Health, or intensive day-Hospital programs delivered by Rehabilitation Facilities, are not subject to the time limitation requirements of the outpatient therapies outlined above and are not combined with outpatient services when calculating total accumulated benefit usage.

## W. Skilled Nursing Facility Care

Room and board and other necessary services furnished by a Skilled Nursing Facility will be provided when a Member requires skilled nursing care of the type provided by the facility. Admission to the facility must be arranged and Certified by PHP and by the Member's Physician. Admission must be appropriate for the Medically Necessary care and rehabilitation of the Member. Skilled Nursing Facility care is provided for up to 60 days per Member, per Calendar Year. **Custodial or Domiciliary Care is not Covered.**

## X. Smoking Cessation

Coverage is provided for Diagnostic Services, Smoking Cessation Counseling and pharmacotherapy. Medical services are provided by licensed healthcare professionals with specific training in managing the Member's Smoking Cessation Program. The program is described as follows:

1. Individual counseling at a Participating Provider/Practitioner's office is Covered under the medical benefit. The Primary Care Practitioner or specialist Copayment applies. There is no limit to the number of visits that are Covered. **Non-Participating Providers/Practitioners are not Covered.**

2. Group Counseling, including classes or a telephone "quit line" are Covered through a Participating Provider/Practitioner. No Copayment will apply and there are no dollar limit or visit maximums. Reimbursements are based on contracted rates.

3. Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group-counseling services at no charge. Members may want to utilize these services. (Contact Member Services for a list of programs.)

4. **Pharmacotherapy Benefits are limited to:**

   a. Prescription Drugs purchased at a Participating Pharmacy.

   b. two 90-day courses of treatment per Calendar Year.

   c. Refer to "Covered Medications" in your Schedule of Benefits for Copayment amounts.

5. **Exclusions:**

   a. Hypnotherapy (The use of therapeutic techniques or principals in conjunction with hypnosis. Hypnosis is the process by which a trained therapist helps the patient become so relaxed that he/she may be able to accept new ways of thinking or reacting to behaviors which the patient wishes to change.)

   b. Over-the-Counter (OTC) drugs, unless listed as a Covered OTC medication on the Preferred Drug Listing.

   c. Acupuncture for Smoking Cessation Counseling is not Covered under the Smoking Cessation Counseling Benefit. Refer to item E. (Complementary Therapies) of this section for Benefits available under the Acupuncture Benefit.

## Y. Transplants

**All transplant benefits, including travel and immunosuppressive medications are limited to a Lifetime Maximum of $500,000**.

1. Human Organ transplant benefits are available for:


**Refer to your Schedule of Benefits to determine which type of transplant Coverage you have.**

**Limited Coverage ( Refer to your Schedule of Benefits to determine which type of transplant Coverage you have)**

Human Organ transplant benefits are available for:

   a. Cornea,

   b. Kidney,

   c. Liver for children with biliary atresia and other rare congenital abnormalities,

   d. Bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott Aldrich syndrome.

**Standard Coverage (Refer to your Schedule of Benefits to determine which type of transplant Coverage you have)**

Human Organ transplant benefits are available for:

   a. Cornea,

   b. Heart,

c. heart/lung,

d. lung,

e. intestinal,

f. kidney,

g. liver,

h. pancreas,

i. pancreas islet cell infusion,

j. bone marrow transplants are Covered **only** for leukemia, aplastic anemia, lymphoma, severe combined immunodeficiency disease (SCID), Wiskott Aldrich syndrome, and multiple myeloma. "Bone Marrow Transplant" includes peripheral blood bone marrow stem cell harvesting and transplantation following high dose chemotherapy.

2. Non-human Organ transplants, except for porcine (pig) heart valve, are **not Covered**.

3. All transplants must meet Medical Necessity criteria as determined by PHP and be Certified by PHP.

4. All Organ transplants must also be deemed Medically Necessary by the Member's Primary Care Physician or a Physician to whom the Member has been Referred. Transplant services shall be **performed at a site approved by PHP.**

5. **Limited travel benefits** are available for the transplant recipient and one other person. **Transportation costs will be Covered only if out of state travel is required.** Reasonable expenses for lodging and meals will be Covered for both out-of-state and in-state, up to a **maximum of $150 per day for both the transplant recipient and companion, combined. All benefits for transportation, lodging and meals are limited to a lifetime maximum of $10,000. This benefit does not include transportation costs for deceased Members.**

6. If there is a living donor that requires surgery to make an Organ available for a Covered transplant for a PHP Member, Coverage is available for expenses incurred by the donor for travel, surgery, laboratory and x-ray services, Organ storage expenses, and inpatient follow-up care only. PHP will pay **Reasonable and Customary** Charges for a **donor** who is not entitled to benefits under any other health benefit plan or policy.

## Z. Women's Health Care

The following services are available for female Members age 13 or over.

1. **Obstetrical/gynecological care** includes annual exams, care related to pregnancy, miscarriage, therapeutic abortions, elective abortions up to 24 weeks and other obstetrical/gynecological services.

2. **Maternity and newborn care – Inpatient and Diagnostic services are subject to Deductible**

   a. **Maternity Coverage** is available to a mother and her newly born child (if enrolled), under this Agreement for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. Hospital admissions must be Certified.

   Inpatient care in excess of 48 hours following a vaginal delivery and 96 hours following a cesarean section will be Covered if determined to be Medically Necessary by the Member's attending Participating Physician. In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her attending Participating Physician. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists including, but not limited to, the criterion that family members or other support person(s) will be available to the mother for the first few days following early discharge.


**Important information. You must enroll your newborn within 31 days of birth.**

   b. **Newborn children of a Subscriber or a Subscriber's spouse** will be Covered from the moment of birth when enrolled as follows:

      (1) The child's signed and completed enrollment Application form must be submitted by the employer Group and received by PHP within 31 days or as specified in the Group Letter of Agreement, from the date of birth.

      (2) If enrollment of a newborn child results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid within the first 31 days or as specified in the Group Letter of Agreement, following the date of birth for the newborn to be enrolled.

   If conditions of (1) and (2) above are not met, the newborn child cannot be enrolled for PHP Coverage until the next Annual Group Enrollment Period.

   **A newborn of a Member's Dependent child cannot be enrolled unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by the court as the newborn's legal guardian.**

c. **Neonatal care** is available for the newborn child of a Subscriber or Subscriber's spouse for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, the newborn stay must be Certified.

d. Benefits for enrolled newborns shall include Coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, and where necessary to protect the life of the infant, transportation, including air transport to the nearest available Tertiary Facility. Enrolled newborn benefits also include newborn visits in the Hospital by the baby's Participating Physician, circumcision, incubator, and routine Hospital nursery charges. **Circumcisions performed other than during the newborn's Hospital stay are only Covered when Medically Necessary.**

3. **High-risk Ambulance Services** in accordance with Section IV. (Benefits) item B. (Ambulance Services).

a. Midwives: Midwifery is the provision of women's health care management in the antepartum, intrapartum, postpartum, and interconceptual periods and infants up to six weeks of age.

**The services of a Licensed Midwife or Certified Nurse Midwife are Covered, subject to the following limitations**:

a. The midwife's services must be provided under the supervision of a licensed Obstetrician or licensed Family Provider/Practitioner.

b. The services must be provided in preparation for or in connection with the delivery of a newborn infant.

c. For purpose of Coverage under this Agreement, the only allowable sites of delivery are a Hospital or a licensed birthing center. **Elective Home Births and any prenatal or postpartum services connected with Elective Home Births are not Covered.** Elective Home Birth means a birth that was planned or intended by the Member or Provider/Practitioner to occur in the home.

d. The combined fees of the midwife and any attending or supervising Physician(s), for all service provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Physician had he/she been the sole Provider/Practitioner of those services.

e. The services of a lay midwife or an unlicensed Midwife are **not Covered.**

4. **Prenatal Maternity Care** benefits which include prenatal care, pregnancy related diagnostic tests (including an alpha-fetoprotein IV screening test for women, generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus), visits to an Obstetrician, Certified Nurse Midwife, or Licensed Midwife, Medically

Necessary nutritional supplements as determined by the attending Physician, childbirth in a Hospital or in a licensed birthing center. Elective Home Births are **not Covered.**

5. **Elective abortions** are Covered when performed prior to the 24th week of pregnancy. **Elective abortions are subject to Deductible.**

6. **Cytologic Screening (PAP Smear), Human Papillomavirus (HPV) screenings** and mammography Coverage described in Section IV. (Benefits) item D. 9 and D. 10.

7. **Mastectomy, Prosthetic Devices and Reconstructive.** Coverage for Medically Necessary surgical removal of the breast (mastectomy) is for not less than 48 hours of Inpatient care following a mastectomy and not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless the attending Physician and patient determine that a shorter period of Hospital stay is appropriate.

   Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer is subject to Copayments consistent with those imposed on other benefits.

   Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.

   Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy. Two bras per year are Covered for Member's with external breast prosthesis. All care must be provided by or under the direction of the Member's Primary Care Physician with appropriate Benefit Certification from PHP.

8. **Osteoporosis Coverage** for services related to the diagnosis, treatment, and appropriate management of osteoporosis when such services are determined to be Medically Necessary by a Participating Provider/Practitioner in consultation with PHP. Such care must be provided by or under the direction of the Member's Primary Care Physician.

## V. BENEFIT CERTIFICATION

***Certain healthcare services require Benefit Certification. This section explains what Benefit Certification is and how it is obtained.***

### A. What is Required?

Certain services and supplies are Covered Benefits only if they are Certified. Benefit Certification means the process whereby Presbyterian Health Plan (PHP) or PHP's delegated Provider/Practitioner contractor reviews and approves in advance the provision of certain Covered Benefits to Members before those services are rendered. If a required Benefit Certification is not obtained for services by Non-Participating Providers/Practitioners, the Member will be responsible for the resulting charges. **Services rendered beyond the scope of the Benefit Certification are not Covered.** Benefit Certification is a tool to help you and your Provider/Practitioner with coordinating your care and benefits.

### B. Who is Responsible?

Benefit Certification of services or supplies rendered by Participating Providers/Practitioners is the responsibility of the Participating Provider/Practitioner. Members will not be liable for charges resulting from the failure of the Participating Provider/Practitioner to obtain such required Benefit Certification. All Benefit Certifications are provided by the PHP Medical Director or the Medical Director's designee.

**Covered services obtained from a Non-Participating Provider/Practitioner or outside the Service Area will not be Covered** unless such services are not reasonably available from a Participating Provider/Practitioner or in cases of an emergency. In determining whether a referral to a Non-Participating Provider/Practitioner is necessary, PHP in consultation with the Member's referring Physician and/or PCP will consider the following circumstances:

1. Availability – The Participating Provider/Practitioner is not reasonably available to see the patient in a timely fashion as dictated by the clinical situation.

2. Competency – The Participating Provider/Practitioner does not have the necessary training or expertise required to render the service or treatment.

3. Geography – The Participating Provider/Practitioner is not located within a reasonable distance from the patient's residence. A "reasonable distance" is defined as travel that would not place the Member at any medical risk.

4. Continuity – If the requested Non-Participating Provider/Practitioner has a well-established professional relationship with the Member and is providing ongoing treatment of a specific medical problem, the Member will be allowed to continue seeing that specialist for a minimum of 30 days as needed to ensure continuity of care.

5. Benefit Certification requested for the convenience of the Member will not be considered to be reasonable.

If required medical services are not available from Participating Providers/Practitioners, the Primary Care Physician must request and obtain written Benefit Certification from the PHP Medical Director before the Member may receive such services. **Services of a Non-Participating Provider/Practitioner will not be Covered** unless this Benefit Certification is obtained prior to receiving the services. Members may be liable for charges resulting from failure to obtain Benefit Certification for services provided by the Non-Participating Provider/Practitioner.

## C. What Services and Supplies Require Benefit Certification?

The Benefit Certification process and requirements are regularly reviewed and updated based on various factors including medical trends, state and federal regulations, and PHP's own policies and procedures. Your PCP or Participating Provider/Practitioner will know when Benefit Certification is necessary. Check with your PCP/Participating Provider/Practitioner or PHP to verify the need for Benefit Certification. The following services and supplies require Benefit Certification as of the date this document was filed with the Department of Insurance:

1. blood glucose specialized monitors/meters, including those for the legally blind;

2. bone growth stimulators;

3. Cancer Clinical Trials (Investigational/Experimental) as specified in Section IV. (Benefits) item C. (Cancer Clinical Trials) of this Agreement;

4. Durable Medical Equipment;

5. foot Orthotics, as specified in Section IV. (Benefits) item I. (Durable Medical Equipment) of this Agreement;

6. home health services/home health intravenous drugs;

7. Hospice care;

8. Hospital admissions, Inpatient non-emergent

9. injectable drugs, (includes Purified Biological Products, Specialty Medications and home health intravenous drugs) except as noted in Section IV. (Benefits) item S. (Covered Medications) of this Agreement;

10. insulin pumps;

11. medical detoxification;

12. Mental health services;

13. Organ transplants;

14. Orthotics;

15. out-of-plan services, excluding emergency or Urgent Care as described in this Agreement;

16. PET (Positron Emission Tomography) Scans;

17. Prescription Drugs: Refer to Section IV. (Benefits) item S. (Covered Medications) and T. (Prescription Drugs – Outpatient (4-Tier)) of this Agreement;

18. Prosthetics;

19. reconstructive and potentially cosmetic procedures;

20. speech/hearing therapy;

21. Skilled Nursing Facility care;

22. special Inpatient services, for example, private room and board and special duty nursing;

23. Substance Abuse services;

24. uterine monitoring, home.

Note: If you lose Coverage under this plan, services received after Coverage ends will not be Covered, even if Benefit Certification was obtained from PHP. Obtaining Benefit Certification does not guarantee you will receive benefits.

## VI. LIMITATIONS

***This section explains what limitations exist on your particular benefit plan.***

**COVERED BENEFITS ARE SUBJECT TO THE LIMITATIONS IDENTIFIED IN THIS SECTION AS WELL AS IN:**

**1. SECTION III. (GENERAL INFORMATION);**

**2. SECTION IV. (BENEFITS);**

**3. SECTION V. (BENEFIT CERTIFICATION); AND**

**4. SECTION VII. (EXCLUSIONS) OF THIS AGREEMENT.**

**PLEASE REVIEW THESE SECTIONS FOR A COMPLETE UNDERSTANDING OF YOUR BENEFITS.**

**A. Choice of Provider/Practitioner**. If more than one type of Provider/Practitioner is qualified to furnish a particular item or Covered Benefit, Presbyterian Health Plan (PHP) may select the type of Provider/Practitioner to be used.

**B. Major Disasters**. In the event of any major disaster, epidemic or other circumstances beyond PHP's control, PHP shall render or attempt to arrange Covered Benefits insofar as practical, according to its best judgment, within the limitations of facilities and personnel as are then available. However, no liability or obligation shall result from nor shall be incurred for the delay or failure to provide any such services due to the lack of available facilities or personnel, if such lack is the result of such disaster, epidemic or other circumstances beyond PHP's control and if PHP has made a good-faith effort to provide or arrange for the provision of such services. Such circumstances include complete or partial disruption of facilities, war, act(s) of terrorism, riot, civil insurrection, disability of a significant part of a Hospital, PHP personnel or Providers/Practitioners or similar causes.

**C. Organ Transplants**. Organ transplants are limited to those procedures and benefits described in Section IV. (Benefits) item Y. (Transplants). Total lifetime benefits per Member for any and all Organ transplants are limited to $500,000.

**D. PHP Continuation**. Members who are on PHP continuation and are also Covered by another Group plan shall receive PHP benefits to the extent that PHP is secondary payer of all eligible charges, subject to the terms, conditions and limitations of this Agreement.

**E. Benefit Certification**. Availability of certain services and supplies are subject to Benefit Certification as specified in Section V. (Benefit Certification).

**F.** **Benefit Limitations.** Some services may be subject to dollar amount and/or visit limitations or may not be available from Non-Participating Providers. Refer to your Schedule of Benefits and Section IV. (Benefits) for these limitations. **All services are subject to the Benefit Certification requirements listed in Section V. (Benefit Certification), the plan limitations listed in this section and the exclusions listed in Section VII. (Exclusions).**

**G.** **Coverage while away from the Service Area.** When a Member is away from the Service Area, **Coverage is limited to Emergency Health Services and Urgent Care.** This limitation does not apply to Dependent children enrolled under the provisions of Section VIII. (Eligibility, Enrollment and Effective Dates) item A. (Who is Eligible?).

## VII. EXCLUSIONS

***This section lists services that are not Covered under your benefit plan. Any exclusion listed would not be applicable if Covered under the Family, Infant and Toddler (FIT) program in accordance with that which is required under N.M.S.A.*** *§ 59A-46-38.1.* ***Refer to Section IV. (Benefits) item J. (Family, Infant and Toddler (FIT) Program).***

**COVERED BENEFITS ARE SUBJECT TO THE EXCLUSIONS IDENTIFIED IN THIS SECTION, AS WELL AS IN:**

**1. SECTION III. (GENERAL INFORMATION);**

**2. SECTION IV. (BENEFITS);**

**3. SECTION V. (BENEFIT CERTIFICATION); AND**

**4. SECTION VI. (LIMITATIONS).**

**PLEASE REVIEW THESE SECTIONS FOR A COMPLETE UNDERSTANDING OF YOUR BENEFITS.**

A. Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be not Medically Necessary or accepted medical practice. This includes any service, which is not generally recognized by the medical community as conforming to accepted medical practice, or any service for which the required approval of a government agency has not been granted at the time the service is provided.

B. **Elective abortions** after the 24th week of pregnancy.

C. **Alternative/complementary therapies**, except as specified in Section IV. (Benefits) item E. (Complementary Therapies) of this Agreement.

D. **Artificial aids** including speech synthesis devices (except items identified as being Covered in Section IV. (Benefits) item I. (Durable Medical Equipment) of this Agreement.

E. **Athletic trainers.**

F. **Autopsies and/or transportation costs** for deceased Members.

G. **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.

H. **Exclusions related to Behavioral Health Services:**

1. Alcoholism and Substance Abuse services, except for Substance Abuse medical detoxification services, unless listed as Covered in your Schedule of Benefits or if the Optional Alcohol/Substance Abuse Rider is included.

2. Halfway houses.

3. Residential Treatment Centers unless for the treatment of Alcoholism and/or Substance Abuse and **only** when listed as Covered in your Schedule of Benefits or if the Optional Alcohol/Substance Abuse Rider is included.

4. Co-dependency treatment.

5. Counseling: sex, pastoral/spiritual, and bereavement counseling.

6. Psychological testing when not Medically Necessary.

7. Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies to whether or not associated with manifest mental illness or other disturbances.

I. **Benefits and services not specified as Covered.**

J. **Biofeedback**, except as specified in Section IV. (Benefits) item E. (Complementary Therapies) of this Agreement.

K. **Exclusions relating to Cancer Clinical Trials:**

1. Any Cancer Clinical Trials provided outside of New Mexico as well as those, that do not meet the requirements listed in Section IV. (Benefits) item C. (Cancer Clinical Trials).

2. Costs of the Clinical Trial that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

3. Services from Non-Participating Providers/Practitioners, unless services from a Participating Provider/Practitioner are not available. Any Non-Participating services must be Certified by Presbyterian Health Plan (PHP) and provided for in New Mexico.

4. The cost of a non-FDA-approved investigational drug, device or procedure.

5. The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Cancer Clinical Trial.

6. Cost associated with managing the research that is associated with the Cancer Clinical Trial.

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

8. Costs of tests that are necessary for the research of the Clinical Trial.

9. Costs paid or not charged for by the Cancer Clinical Trial Providers.

L. **Care for conditions which state or local law requires be treated** in a public or correctional facility.

M. **Care for military service connected disabilities** to which the Member is legally entitled and for which facilities are reasonably available to the Member.

N. **Charges that are determined to be unreasonable** by PHP.

O. **Circumcisions** performed other than during the newborn's Hospital unless Medically Necessary.

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

Q. **Common disposable medical supplies** that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze, (such as 4 by 4's) and ace bandages, except when provided in a Hospital or Physician's office or by home health professional.

R. **Convenience item(s):** an appliance, devise, object or service that is for comfort and ease and is not primarily medical in nature, such as shower or tub stools/chairs, seats, bath grab bars, shower heads, hot tubs/whirlpools/Jacuzzis, vaporizers, accessories such as baskets, trays, seat or shades for wheelchairs, walkers and strollers, clothing, pillows, fans, humidifiers, and special beds and chairs (excluding those Covered under Durable Medical Equipment Benefits).

S. **Corrective eyeglasses** or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, except as identified in Section IV. (Benefits) item I. (Durable Medical Equipment) of this Agreement.

T. **Cosmetic Surgery.** 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 for truncal veins), and nasal rhinoplasty.

U. **Cosmetic treatments**, **devices, orthotics, and medications,** including treatment of hair-loss.

V. **Court ordered evaluation or treatment**, or treatment that is a condition of parole or probation or **in lieu of sentencing**, such as alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.

W. **Custodial or Domiciliary Care.**

X. **Exclusions relating to dental services:**

1. Dental care and dental x-rays, except as provided in Section IV. (Benefits) item F. (Dental Services/TMJ/CMJ) hospitalization, day surgery, outpatient services and/or anesthesia for Non-Covered dental services are not Covered, unless the patient has a non-dental physical condition that makes hospitalization or anesthesia Medically Necessary, and the need for such services has been approved in consultation with PHP.

2. Dental implants.

3. Malocclusion treatment, if part of routine dental care and orthodontics.

4. Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.

Y. **Exclusions related to Durable Medical Equipment:**

1. For plans with limited DME coverage: Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices except as indicated in Section IV. (Benefits) item G. (Diabetes Services), item I.6 (Eye Refractions, Eyeglasses and Contact Lenses) and item Z.7 (Women's Healthcare, Mastectomy, Prosthetic Devices and Reconstructive Surgery).

2. Duplicate Durable Medical Equipment items (i.e. for home and office).

3. Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by PHP), Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.

4. Custom-Fabricated orthotics/Orthosis are not Covered except for knee-ankle-foot Orthosis (AFO and/or KAFO) except for Members up to eight years old.

5. Upgraded or deluxe Durable Medical Equipment.

6. Additional wheelchairs, if the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair.

7. Repair or replacement of Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience.

8. Repair and replacement of items under the manufacturer or supplier's warranty.

Z. **Elastic support hose**.

AA. **Elective Home Birth** and any prenatal or postpartum services connected with an Elective Home Birth. Allowable sites for a delivery of a child are Hospitals and licensed birthing centers. Elective Home Birth means a birth that was planned or intended by the Member or Provider/Practitioner to occur in the home.

AB. **Exercise equipment** and videos, personal trainers, club membership and weight reduction programs.

AC. Drugs, medicines, treatments, procedures, or devices that PHP determines **are Experimental or Investigational.** This means that one or more of the following is true:

1. the drug, medicine or device cannot be marketed lawfully without approval of the U.S. Food and Drug Administration ("FDA") and approval for marketing has not been given at the time the drug, medicine or device is furnished;

2. the FDA has determined that use of the drug, medicine or device is contraindicated for the particular indication for which it has been prescribed;

3. reliable evidence shows that the drug, medicine, and/or device, treatment, or procedure is the subject of ongoing phase I, II, or III Clinical Trials, except as specified in Section IV. (Benefits) item C. (Cancer Clinical Trials), or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or

4. reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

5. Reliable evidence means only published reports and articles in authoritative peer reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure or device; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure or device.

AD. **Extracorporeal shock wave therapy** involving the musculoskeletal system.

AE. Exclusions relating to **Genetic Inborn Errors of Metabolism**:

1. Food substitutes for lactose intolerance including soy foods or formulas or other Over-the-Counter (OTC) digestive aids, unless listed as a Covered OTC medication on the Preferred Drug Listing.

2. Organic foods,

3. Ordinary foodstuffs that might be part of an exclusionary diet,

4. Food substitutes that do not qualify as Special Medical Foods,

5. Any product that does not require a Physician's prescription,

6. Special Medical Foods for conditions that are not present at birth,

7. Food items purchased at a health food, vitamin or similar store,

8. Foods purchased on the Internet, and

9. Special Medical Foods for conditions including, but not limited to: Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, and Allergies to food products.

AF. **Gloves**, unless part of a wound treatment kit.

AG. **Hair-loss (baldness)** treatments, medications, supplies and devices, including wigs, and special brushes.

AH. **Hearing aids** and the evaluation for the fitting of hearing aids.

AI. **Home Sleep Studies.**

AJ. **Hospice benefits** are not Covered for the following services:

1. food, housing, and delivered meals;

2. volunteer services;

3. comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits);

4. homemaker and housekeeping services;

5. private duty nursing;

6. pastoral and spiritual counseling; and

7. bereavement counseling.

AK. **Hypnotherapy** except as part of anesthesia preparation or chronic pain management.

AL. The following **Infertility Services/Artificial conception services are not Covered**: donor sperm, In-vitro, GIFT and ZIFT fertilization.

AM. **Massage Therapy** unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program.

AN. Services of a lay **Midwife** or an unlicensed Midwife.

AO. **A newborn of a Member's Dependent child**, unless the Subscriber had legally adopted the newborn, or unless the court has appointed the Subscriber as the newborn's legal guardian.

AP. Use of an emergency facility for **non-emergent services**.

AQ. **Non-human Organ transplants** except for porcine (pig) heart valve.

AR. Covered services obtained from a **Non-Participating Provider/Practitioner,** except for the following:

1. services which are not available from a Participating Provider/Practitioner and have been approved by PHP before services are rendered, or

2. in cases of an emergency as defined in Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health/Observation and Trauma services) of this Agreement.

AS. **Nutritional supplements** except as described in Section IV. (Benefits) item S. (Covered Medications).

AT. The medical and Hospital services of an **Organ transplant donor** when the recipient of an Organ transplant is not a Member or when the transplant procedure is not Covered.

AU. Services, other than emergent or urgent in nature, received **outside of the United States**.

AV. **Personal or comfort items**, **services or treatments** such as, but not limited to, aromatherapy, pet therapy, homemaker and housekeeping services.

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

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

AY. Physician Home Visits.

AZ. Exclusions relating to **Prescription Drugs:**

1. Compound Prescriptions.

2. New medications for which the determination of criteria for Coverage has not yet been established by PHP's Pharmacy and Therapeutics Committee.

3. Over-The-Counter medications and drugs for which there is a non-prescription equivalent available with the exception of approved OTC medications as determined by PHP's Pharmacy and Therapeutics Committee. Refer to the PHP Preferred Drug Listing for a list of Covered OTC medications.

4. Outpatient Prescription Drugs, except as described in Section IV. (Benefits) item S. (Covered Medications) of this Agreement. Unless listed as Covered in your Schedule of Benefits or if the Optional Prescription Drug Rider is included, refer to Section IV. (Benefits) item T. (Prescription Drugs – (Outpatient (4-Tier)).

5. Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained.

6. Prescription Drugs (as listed as Covered in your Schedule of Benefits, Optional Prescription Drug Rider, if included and this Group Subscriber Agreement) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient Pharmacy is not available.

7. Prescriptions ordered by a Non-Participating Provider/Practitioner or purchased at a Non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area.

8. Replacement prescriptions resulting from loss, theft, or destruction.

AAA. **Private duty nursing.**

AAB. **Reversals of voluntary sterilization**.

AAC. **Routine foot care**, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.

AAD. To the extent determined by law**, services for which the Member or Dependent is eligible under any governmental program** (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member or Dependent.

AAE. **Services requiring Benefit Certification** when Benefit Certification was not obtained. (Members are not liable when a Participating Provider/Practitioner does not request Benefit Certification).

AAF. **Sex transformation** surgery and drugs relating to sex transformation.

AAG. Treatment for **sexual dysfunction**, including medication, counseling, and clinics, except for penile prosthesis as listed under Section IV. (Benefits) item I. (Durable Medical Equipment) of this Agreement.

AAH. **Storage or banking** of sperm, ova (human eggs), embryos, zygotes or other human tissue.

AAI. **"Telephone visits and electronic mail (E-mail)"** by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient. Also "get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided.

AAJ. **Transportation costs** for deceased Members.

AAK. **Travel and lodging expenses** except as provided in Section IV. (Benefits) item Y. (Transplants) of this Agreement.

AAL. Exclusions relating to **vision services:**

1. Eye movement therapy.

2. Eye refractive procedures including radial keratotomy, laser procedures, and other techniques.

3. Routine vision care and Eye Refractions for determining prescriptions for corrective lenses, except as identified in Section IV. (Benefits) I. (Durable Medical Equipment) of this Agreement.

4. Visual training.

AAM. **Vocational Rehabilitation** Services and Long-Term Rehabilitation Service.

AAN. Costs for **extended warranties** and premiums for other insurance Coverage.

AAO. Treatments and medications for the purpose of **weight reduction** or control except for Medically Necessary treatment for morbid obesity, (Medications are Covered only if the Outpatient Prescription Drug Benefits are included). Refer to your Schedule of Benefits to determine your Outpatient Prescription Drug Coverage.

AAP. Treatment of **work-related accidents or injuries** or occupational illness or disease if the Member is required to be Covered under workers' compensation insurance, whether or not such Coverage actually exists.

**PHP shall not be obligated to provide any services under this Agreement on or after the effective date of termination of this Group Subscriber Agreement. See Section XIII. (Termination) item F.**

## VIII. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

***This section explains how "Subscribers" and their "Dependents" are eligible to enroll in this plan. This section also provides details on effective dates of Coverage as well as what changes in family status or employment status based on a qualifying event, will allow you to change your enrollment elections.***

### A. Who is Eligible?

1. **Subscribers**. To be eligible to enroll as a Subscriber, you must:

   a. physically live or physically work in Presbyterian Health Plan's (PHP's) Service Area as defined by PHP; and

   b. be a permanent employee of the Group, currently working a minimum of 20 hours per week. Note: Some employers may require that you work more than this minimum to be eligible for benefits, and;

   c. be eligible to participate in medical and Hospital benefits arranged by the Group; and

   d. meet any other eligibility criteria as specified by the Group, and agreed to in writing by PHP.

2. **Dependents**. To be eligible to be enrolled as a Dependent for purposes of Coverage as a Member of PHP, an individual must:

   a. be your legally married spouse, as defined by New Mexico law and physically live in PHP's Service Area as defined by PHP; or

   b. be your Dependent unmarried child who is:

      (1) under 25 years of age or such other age as specified in the Group Letter of Agreement;

      (2) your own or legally adopted child or a child for whom you are legal guardian or have legal custody as defined by New Mexico state law;

      (3) in your Custodial Care as appointed by court order;

      **Note**: Only the eligible court ordered Dependent will be allowed to enroll. The eligible Dependent will become effective on the date in accordance with the court order. If the court order does not stipulate an effective date, the Dependent will become effective the 1st of the month following the date the court order was filed with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent will be the 1st of the month following receipt of the request by the employer. The employee of the Dependent must meet any applicable waiting periods imposed by the Group and only the eligible, court ordered Dependent will be allowed to enroll.

(4) your stepchild (**foster children are not eligible**);

(5) a child for which a court or qualified administrative order is imposed or a child of non-custodial parent(s),

who depends on you for support or normally lives in your household. Dependent children who are eligible to be enrolled under this item 2.b. are not required to live in the Service Area; however, Coverage is limited to Emergency Health Services or Urgent Care when not in the Service Area. PHP may require proof of eligibility. Enrollment of a Dependent child under this Contract shall terminate upon attainment of the child's 25th birthday or as specified in the Group Letter of Agreement, except as provided in 2.d. below or earlier marriage; or

c. be your or your spouse's Dependent unmarried child, under 25 years of age or as specified in the Group Letter of Agreement, for whom you are required by court order to provide healthcare Coverage. Dependent children who are eligible to be enrolled under this item 2.c. are not required to live in the Service Area and Coverage is provided as described in Section III. (General Information) item L. (Court Ordered Coverage for Dependent Children). Enrollment of a Dependent child under this Contract shall terminate at the end of the month upon attainment of the child's 25th birthday or as specified in the Group Letter of Agreement.

d. The attainment of the limiting age referenced in 2.b. and 2.c., above, shall not terminate the Coverage under this Agreement of a Dependent unmarried child who is totally and permanently disabled. The Dependent must be incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish proof of such disability, incapacity and dependence to PHP within 31 days of the Dependent child's attainment of age 25, or as specified in the Group Letter of Agreement and each birthday thereafter if requested by PHP.

3. No person shall be eligible to enroll who has had a prior PHP Contract terminated for Good Cause as outlined in Section XIII. (Termination) of this Agreement or any similar sections of other PHP Contracts, unless approved in writing by PHP.

**B. Enrollment and Effective Dates.**

Eligible Subscribers and Dependents may enroll at the following times and in the following manner:

1. Subscribers, together with eligible Dependents, may enroll by submitting completed Application forms at the time the Group Letter of Agreement is executed by PHP and the Group. The signed and completed Application form must be received by PHP within 31 days of the Group Letter of Agreement effective date.

2. Subscribers and eligible Dependents may begin receiving services for Covered Benefits at 12:01 a.m. on the effective date of the Group Letter of Agreement and after all of the requirements below have been met:

a. the names of the Subscribers and eligible Dependents have been received in writing by PHP; and

b. the appropriate advance Prepayment (or as specified in the Group Letter of Agreement) has been received by PHP for all listed Subscribers and eligible Dependents.

3. There shall be an Annual Group Enrollment Period each Contract Year. During this time, employees who have previously waived Coverage may enroll, and/or add eligible Dependents. This is the only time in which employees who have been Covered can switch plan options. The effective date of Coverage for new Members who enroll during the Annual Group Enrollment Period shall be 12:01 a.m. on the date of the Contract Year for which they enroll. The signed and completed Application form must be received by PHP by that date.

4. Newly hired Employees of a Group must enroll within 31 days or as specified in the Group Letter of Agreement, after becoming eligible. The effective time and date of Coverage will be 12:01 a.m. on the first of the month or as specified in the Group Letter of Agreement, following completion of the Group's eligibility requirements. If enrollment is not accomplished within the 31-day period or as specified in the Group Letter of Agreement, the next earliest time the eligible Subscriber and eligible Dependents may enroll is the next occurring Annual Group Enrollment Period except as specifically described below.

5. A child for whom a Subscriber becomes a legal guardian pursuant to court order is eligible to be enrolled as a Dependent for the duration of the guardianship unless otherwise ineligible for Coverage. Such child must be enrolled within 31 days or as specified in the Group Letter of Agreement, of the date of the court order granting guardianship. The Dependent will become a Member on the first day of the month following the date the order is filed with the clerk of the court or as specified in the Group Letter of Agreement.

6. A child, for whom a Subscriber has been ordered by a court of law to provide healthcare Coverage, is eligible to be enrolled as a Dependent, provided that the Subscriber has met the Group's waiting period requirements. Coverage and the request for enrollment is made within 31 days or as specified in the Group Letter of Agreement, from the date on which the Group receives the court order. The Dependent will become a Member on the day stipulated by the court order. However, the Subscriber will not be eligible to enroll until the next annual enrollment period.

7. An eligible person may enroll as a Subscriber or Dependent after the initial eligibility period if the person loses Coverage under all of the following circumstances:

a. the person was Covered under a Group health plan or had individual health insurance Coverage at the time the person was initially eligible to enroll; and

b. the employee stated in writing, if requested by the employer at the time the employee was initially eligible to enroll, that he and/or his Dependents were not enrolling because of such other Coverage; and

c. the person's Coverage under the other plan or insurance:

(1) was under a COBRA continuation provision and the Coverage under that provision was exhausted (and not voluntarily terminated);

(2) was not under a COBRA continuation period and either the Coverage was terminated as a result of loss of eligibility or employer contributions toward the Coverage were terminated; and

d. Application was made within 31 days of the date Coverage under COBRA was exhausted, or the date the Coverage (or the employer's contribution toward Coverage) was terminated.

8. Upon expiration of any applicable 31-day period for eligibility, enrollment in PHP can occur only during a subsequent Annual Group Enrollment Period.

**C. Special Enrollment**

1. An employee who failed to enroll in PHP during a previous enrollment period but who would otherwise be eligible for Coverage may enroll in PHP due to a Special Enrollment event. Application must be made within 31 days of acquiring a new Dependent through marriage, birth, adoption or placement for adoption or as specified in the Group Letter of Agreement. Special Enrollment applies to the Subscriber, spouse and "Eligible Dependents," which include the new Dependents acquired because of the marriage, or newborn/adopted children who triggered the event-but not other siblings.

2. Effective date of enrollment:

a. In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan, provided it is received within 31 days of the date of marriage.

b. In the case of a Dependent's birth, the date of such birth; and

c. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

**D. Family Status or Employment Status Changes.**

Notwithstanding the provisions specified in item C. (Special Enrollment) of this Section, Subscribers may make certain changes to their benefit elections within 31 days or as specified in the Group Letter of Agreement, of a change in family/employment status. Evidence of a change in family/employment status must be provided to PHP in order to change a Subscriber's benefit elections. Any change in Coverage will become effective on the first day of the month following the date of the status change or as specified in the Group Letter of Agreement. The only exceptions would be the birth and adoption, where the additional Coverage would take place immediately upon enrollment. Termination of a Dependent is not a qualifying even for the Subscriber to change benefit plans. The following family/employment status changes are recognized by PHP as:

1. Marriage

   A Subscriber's newly acquired spouse (and any child of the spouse eligible for Coverage under item A.2 of this Section) is eligible to be enrolled as a Dependent. Such newly acquired spouse must be enrolled within 31 days from the date of marriage or as specified in the Group Letter of Agreement, Coverage will become effective on the first day of the month following the date of marriage, or as specified in the Group Letter of Agreement.

2. Divorce or legal separation;

3. birth or adoption of a child.

   a. Newborn children of a Subscriber or Subscriber's spouse will be Covered from moment of birth when enrolled as follows:

      (1) the signed and completed Enrollment Application form must be submitted to the employer Group and received by PHP within 31 days or as specified in the Group Letter of Agreement, from the date of birth, and

      (2) if enrollment of a newborn child results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid within the first 31 days or as specified in the Group Letter of Agreement, following the date of birth for the newborn to be Covered.

      If conditions (1) and (2) above are not met, the newborn child cannot be enrolled for PHP Coverage until the next following Annual Group Enrollment Period. Please refer to Section IV. (Benefits) item Z. (Women's Health Care), Section V. (Benefit Certification), Section VI. (Limitations) and Section VII. (Exclusions) to fully understand the benefits and requirements for Maternity and newborn Coverage.

   b. A child for whom the Subscriber has commenced adoption proceedings is eligible to be enrolled as a Dependent and will be Covered from the date of placement for the purpose of adoption if the child is enrolled and any applicable Prepayment made within 31 days or as specified in the Group Letter of Agreement, of the date of placement. The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Such child shall continue to be eligible for Coverage unless placement is disrupted prior to legal adoption. Placement terminates or is disrupted when the legal obligation terminates.

4. death of a spouse or Dependent child;

5. a change in the Subscriber's spouse's employment (loss of job, or a new job that provides dependent care assistance or other healthcare Coverage, however, annual enrollment for a spouse's plan is not a family status change);

6. a change in legal responsibility for a child;

7. the 25th birthday of a Dependent child

8. marriage of a Dependent child;

9. court order/qualified administrative order to provide health insurance for an eligible Dependent;

   **Note**: Only the eligible court ordered Dependent will be allowed to enroll. The eligible Dependent will become effective on the date in accordance with the court order. If the court order does not stipulate an effective date, the Dependent will become effective the 1st of the month following the date the court order was filed with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent will be the 1st of the month following receipt of the request by the employer. The employee of the Dependent must meet any applicable waiting periods imposed by the Group and only the eligible, court ordered Dependent will be allowed to enroll. The Subscriber is not eligible to enroll until the next annual enrollment period.

10. disqualification or re-qualification of a Dependent;

11. unpaid leave of absence for the Subscriber or spouse;

12. bankruptcy;

13. change in employment status (regular part-time to regular full-time or vice versa);

14. significant change in the cost of a spouse's current plan (50% or greater); and

15. an employment transfer that results in a change of residence.

## IX. CLAIMS

***Your healthcare benefits are paid according to the conditions outlined in this section. This section also outlines the process should you need to be reimbursed for services you paid for.***

### A. Participating Providers/Practitioners

Presbyterian Health Plan (PHP) pays Participating Providers/Practitioners directly for Covered services provided to Members. A Member should not be required to pay sums to any Participating Provider/Practitioner except for required Copayments and Co-insurance, if applicable. Members will be responsible for payment of charges for missed appointments or appointments canceled without adequate notice. If a Member is asked by a Primary Care Physician to make any Copayments in addition to those Copayments specified in this Agreement, the Member should consult the PHP Member Services Department before making any such additional Copayments. A Member shall not be liable to a Participating Provider/Practitioner for any sums owed to the Provider/Practitioner by PHP.

### B. Non-Participating Provider/Practitioner – Benefit Certification

Except for Emergency Health Services described in Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation/Trauma Services); a Member must receive written Benefit Certification from PHP prior to receiving services from a Non-Participating Provider/Practitioner. Otherwise, the Member will be responsible for all charges incurred.

### C. Non-Participating Providers/Practitioners

Members who receive Certified benefits from an approved Non-Participating Provider/Practitioner, as specified in Section III. (General Information) item F. (Participating and Non-Participating Providers/Practitioners), may be required to make full payment to that Provider/Practitioner at the time services are rendered. The Member should then submit satisfactory evidence to PHP that such payment was made to a Non-Participating Provider/Practitioner. Upon review and approval of the Member's evidence of payment, PHP shall reimburse the Member for Covered Benefits, based upon Reasonable and Customary Charges, less any required Copayment the Member would have been required to pay if the services had been obtained from a Participating Provider/Practitioner. **The Member will be responsible for charges not specifically Covered by PHP.** Emergency Health Services rendered to a Member while traveling outside of PHP's Service Area shall be Covered as specified in Section IV. (Benefits) item A. (Accidental Injury /Urgent Care /Emergency Health Care/ Observation/Trauma Services) of this Agreement. Member's relying on a Non-Participating Provider/Practitioner to file a claim on their behalf are responsible for ensuring claims have been submitted within one year from the date of service. Any such charge shall be paid only upon receipt of written proof satisfactory to PHP of the occurrence, character and extent of the event and services for which claim is made.

## D. Procedure for Reimbursement

If a charge is made to a Member for Covered Benefits, written proof of such charge must be furnished to PHP within 90 days after performance of the service to receive reimbursement. Any such charge shall be paid only upon receipt of written proof satisfactory to PHP of the occurrence, character and extent of the event and services for which claim is made.

If you need a claim form please contact the PHP Member Service Department. Claim forms are also available on our website at www.phs.org. Please submit your completed claim form to:

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

## E. Services Received Outside the United States

Benefits are available for emergent and urgent services received outside the United States. These services are Covered as explained in Section IV. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Health Care/Observation/Trauma Services) of this Agreement. Members are responsible for ensuring that claims are appropriately translated and that the monetary exchange is clearly identified when submitting claims for services received outside the United States.

## F. Fraud

Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. PHP may terminate a Member for any type of fraudulent activity. For further information regarding Fraud please refer to Section III. (General Information) item U. (Fraud).

## X. EFFECT OF OTHER COVERAGE

***Some Members may have medical Coverage through other Group health benefit plans. This section explains how Presbyterian Health Plan (PHP) coordinates these benefits along with your Presbyterian Health Plan Coverage. This section does not apply to Individual health policies.***

### A. Coordination of Benefits

1. If a Member is also Covered under any other health benefit plan, other public or private Group programs, or any other health insurance policy, the benefits provided or payable hereunder shall be reduced to the extent that benefits are available to the Member under such other plan, policy or program whether or not a claim is made for the same.

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

   a. Employee/Dependent Rule

      (1) The plan which Covers the Member as an employee pays first; and

      (2) The plan, which Covers the Member as a Dependent, pays second.

   b. Birthday Rule for Dependent children of parents NOT separated or divorced.

      (1) The plan, which Covers the parent whose birthday falls earlier in the year, pays first. The plan, which Covers the parent whose birthday falls later in the year, pays second. The birthday order is determined by the month and the day of birth, not the year of birth.

      (2) If both parents have the same month and day of birth, the plan that Covered the parent longer, will pay claims first. The plan, which Covered the parent for a shorter period of time, pays second.

   c. Dependent children of separated or divorced parents.

      (1) The plan of the parent decreed by a court of law to have responsibility for medical Coverage pays first.

      (2) In the absence of a court order:

         (a) the plan of the parent with physical custody of the child pays first;

         (b) the plan of the spouse of the parent with physical custody (i.e., the stepparent) pays second; and

(c) the plan of the parent not having physical custody of the child pays third.

d. Active/Inactive.

(1) The plan which Covers the Member as an active employee (or Dependent of an active employee) pays first; and

(2) The plan, which Covers the Member as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.

e. Longer/Shorter. In the case of a Member who is the Contract holder under more than one Group health insurance policy, then the plan that has Covered the Member for a longer period of time will pay first. The start of a new plan does not include a change of insurance carrier by the employer.

f. No Coordination Provision. In spite of rules a, b, c, d, or e, the plan that has no provision regarding coordination of benefits will pay first.

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

4. For purposes of coordination of benefits, PHP

a. may release, request, or obtain claim information from any individual or organization. In addition, any Member claiming benefits from PHP shall furnish PHP with any information which it may require; and

b. has the right, if overpayment is made by PHP because of the Member's failure to report other Coverage or any other reason, to recover such excess payment from any individual to whom, or for whom, such payments were made; and

c. will not be obligated to pay for Non-Covered services or Covered Benefits not obtained in compliance with PHP's policies and procedures.

5. Members who are on COBRA continuation and are also Covered by another Group plan shall receive PHP benefits to the extent that PHP is secondary payer of all eligible charges, subject to the terms, conditions and limitation of this Agreement.

**B**. **Medicare**

The benefits under this Agreement for Members enrolled in Medicare are not designed to duplicate any benefit to which the Member is entitled under the Social Security Act. Benefits will be coordinated in compliance with current applicable federal regulations.

## C. Medicaid

Benefits payable by PHP on behalf of an Enrollee who is qualified for Medicaid will be paid to the state Human Services Department, or its designee, when:

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

2. the payment for the services in question has been made by the state Human Services Department to the Medicaid Provider/Practitioner.

## D. Med-Pay (Motor Vehicle, Homeowners Policies)

If a Member is Covered under a motor vehicle or homeowners insurance policy which provides benefits for medical expenses resulting from a motor vehicle accident or accident in the Member's own home, the Member shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are Covered by their motor vehicle or home owners insurance policy. If such benefits have been provided by PHP, PHP shall have the right to recover any benefits provided from the motor vehicle or homeowner's insurer or the Member to the extent they are available under the motor vehicle or homeowner's insurance policy.

## E. Subrogation (Recovering Healthcare Expenses from Others)

1. The benefits under this Agreement will be available to a Member who is injured by the act or omission of another person, firm, operation or entity. If a Member receives benefits under this Agreement for treatment of such injuries, PHP will be subrogated to the rights of the Member or the Personal Representative of a deceased Member, or Dependent Member, to the extent of all such payments made by PHP for such benefits. This means that if PHP provides or pays benefits, a Member must repay PHP the amounts recovered in any lawsuit, settlement, or by any other means. This rule applies to any and all monies 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.

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

   a. any claims or lawsuits made against any person, firm or entity responsible for any injuries for which PHP has paid benefits; or

   b. any claim or lawsuit against any insurance company, or uninsured or underinsured motorist insurance carrier.

Settlement of a legal claim or controversy without prior notice to PHP is a violation of this Agreement. In the event a Member fails to cooperate with PHP or takes any action, through agents or otherwise, to interfere with the exercise of PHP's subrogation right, PHP may recover its benefit payments from that Member.

2. When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both the Member and PHP, PHP will, upon request by the Member or the Member's attorney, share such collection costs and legal expenses, in a manner that is fair and equitable, but only if PHP receives appropriate documentation of such collection costs and legal expenses.

## XI. COMPLAINTS, GRIEVANCES AND APPEALS

***This section explains how to file a Complaint, Grievance and Appeal.***

### Overview

Many Grievances or problems can be handled informally by calling the PHP's Consumer Assistance Office at **(505) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD **(505) 923-5699**, TTY/TDD toll-free **(877) 298-7407** or visit our website at www.phs.org. 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 adverse determination Grievance review procedure. See "A" in this section.

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

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 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) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD for the hearing impaired **at (505) 923-5699** 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.

### A. Adverse Determination Grievance 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 24 hours where circumstances require expedited review and five working days for all other cases. If PHP's initial review results in the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the determination and of your right to request an internal review by PHP.

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

Presbyterian Health Plan
Grievance Department
2501 Buena Vista Drive SE
Albuquerque, NM 87106
**(505) 923-5644** or toll-free at **1-800-356-2219**
**FAX (505) 923-6111**
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 the healthcare insurer.

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

*External Review by the 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:

1. mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;

2. e-mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau at mhcb.grievances@state.nm.us; or

3. 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 to assist you in this process.

## B. Administrative Grievance Procedures

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

will review the Grievance and provide you with a written decision within 15 working days from receipt of the Grievance.

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 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 seven working days after the hearing.

*External Review by the Superintendent of Insurance*: If you are dissatisfied with the results of the review by PHP's reconsideration committee, 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:

1. mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;

2. e-mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau at mhcb.grievances@state.nm.us; or

3. fax to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, at **(505) 827-4734.**

C. **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, PHP cannot take retaliatory action against you for filing a Grievance under this health benefits plan.

## XII. RECORDS

***Your medical records are important documents needed in order to administer your benefit plan. This section explains how Presbyterian Health Plan (PHP) ensures the confidentiality of those records and how these records are used to administer your benefit plan.***

### A. Creation of Non-Medical Records

PHP shall keep Member records related to identification information, which does not specifically relate to the Member's medical diagnosis or treatment. The individual Member and/or Group shall forward information periodically as may be required by PHP in connection with the administration of this Agreement.

### B. Accuracy of Information

PHP shall not be liable to fulfill any obligation, which is dependent upon information submitted by the Group 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.

### C. 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.

### D. 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 Department of Insurance (DOI).

## E. 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.

### 1. 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.

PHP 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 PHP.

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

a. request restrictions on certain uses and disclosures of PHI, although PHP is not required to agree to a requested restriction;

b. receive confidential communications of PHI from PHP;

c. with certain exceptions, inspect and receive a copy of PHI;

d. request an amendment to PHI you believe to be incorrect or incomplete;

e. receive an accounting of certain disclosures of PHI; and

f. obtain a paper copy of the Notice of Privacy Practices from PHP upon request (even if the Member previously agreed to receive the Notice(s) electronically).

### 2. Access to PHI

All confidential documents are kept in a physically secure location with access limited to authorized Plan personnel only. You (or your legal guardian/Personal Representative) have the right, with certain exceptions, to request access to inspect and obtain a copy of your PHI. Presbyterian may charge a reasonable fee for providing a copy, summary or explanation of the information you request. If there is a few, 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:

a. Psychotherapy Notes; or

b. Information gathered in reasonable expectation of, or for use in, a civil, criminal, or administrative action or proceeding; or

c. PHI maintained by PHP 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

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

3. **Routine Uses and Disclosures of PHI**

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

a. claims payment;

b. fraud and abuse prevention;

c. data collection;

d. performance measurements;

e. meeting state and federal requirements;

f. utilization management;

g. accreditation activities;

h. preventive health services;

i. 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

j. responding to Member requests for information, products or services.

PHP 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 you 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.

4. **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, Providers/Practitioners shall request 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 PHP at the time of the Member's first visit to the Provider/Practitioner.

In the event that the Provider/Practitioner fails to obtain such consent for disclosure to PHP, or you refuse to sign such consent for disclosure to PHP, PHP shall use its best efforts to obtain such written consent from you (or Member's legal guardian/Personal Representative) prior to the Provider's/Practitioner's release of PHI (i.e. health records) to PHP 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 PHI by any person or entity including without limitation, Providers/Practitioners and insurance companies to PHP 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 PHP. 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 disease, 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 Member Services Department. Authorization Forms will be kept in your medical record or enrollment file.

5. **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.

6. **Right to Request Amendments (Changes) to PHI**

PHP recognizes your right to request amendment of PHI or a record containing PHI for as long as the PHI is maintained in our records. PHP Member Services will accept written requests to amend PHI. PHP must approve or deny your request to amend the disputed PHI no later than 60 days after receipt of the request. If PHP is unable to take an action within the required timeframe, the Plan may take up to 30 additional days, provided that, no later than 60 days after receiving your request, the Plan provides you with a written statement of the reason for the delay and date by which PHP will complete its action on your request and notify you in writing of the determination no later than 60-90 days after receipt of such a request.

7. **Process for Members to Request an Accounting of Disclosures of PHI**

You (or Members 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 PHP the accounting will show when PHP disclosed PHI about you to others without authorization from you.

8. **Restriction of PHI use or Disclosures:**

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

a. PHP's Treatment, Payment and Healthcare Operations; and

b. to persons involved in your care (e.g., family member, other relative, close personal friend, or any other person identified by the Member); and

c. for notification purposes of your location, general condition, or death; and

d. to a public or private Entity authorized by law or its charter to assist in disaster relief efforts.

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

9. **Use of Measurement Data**

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

10. **Internal Protection of Oral, Written and Electronic PHI Across PHP**

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

a. PHI is accessed by plan personnel only if such information is necessary to the performance of job related tasks.

b. PHI is not discussed inside or outside the facility, unless the data is necessary to the performance of job related tasks.

c. PHI, reports and other written materials are reasonably safeguarded throughout the facility against unauthorized access by Plan personnel or public viewing.

d. All employees, volunteers, and any external entity with a business relationship with PHP that involves health information will be held responsible for the proper handling of PHP'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.

11. **Web Site Internet Information**

PHP 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:

a. Website traffic statistics, including:

(1) Where visitor traffic comes from

(2) How traffic flows within the website

(3) Browser type

We monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful.

b. Personal information you provide us (such as your name, address, billing information, health plan Member status, etc.) if you fill out a form on the PHS website.

PHP 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.

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

PHP policies and procedures prohibit sharing your PHI with any fully insured employer Groups plan sponsor without authorization for the Member (or Member's legal guardian/Personal Representative). PHP is careful not to release PHI to your employer as part of routine financial and operating reports. We may disclose summary health information that does not identify individual Members to plan sponsors for allowable purposes. We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards as permitted by law.

If you have any questions regarding your PHI or would like to access your health records, you can call PHP Member Services at **(505) 923-5678**, toll-free **1-800-356-2219**, or TTY/TDD for the Hearing Impaired **(505) 923-5699**, TTY/TDD toll-free **1-877-298-7407** or visit our website at www.phs.org. PHP Member Services is available Monday through Friday, 7 a.m. to 6.p.m. to assist you.

## XIII. TERMINATION

***This section explains what conditions can cancel your Presbyterian Health Plan (PHP) Coverage.***

A. This Agreement shall be canceled and shall terminate in the event that any one of the following conditions occurs:

1. **Non-Payment: Group Membership Coverage**. In the event any Contract charge, including a Prepayment and any applicable finance charge or charges, is not paid to PHP when due by the Group, a notice of cancellation shall be mailed by PHP to the Group, which shall then immediately forward to each Subscriber by first-class mail at his/her current address a legible copy of such notice. Receipt by PHP of payment of the Contract charge (including any Prepayment and all other applicable amounts and charges) within 15 days of the issuance of the notice of cancellation shall be sufficient to prevent cancellation and termination under this paragraph. If payment of such charge is not received within this 15-day period, PHP may, at its option, either:

   a. require that a new Application for Coverage be submitted, notifying the Group of the conditions under which a new Contract will be issued or the original Application reinstated; or

   b. elect to abide by this cancellation by returning to the Group within 20 business days after receipt of any Prepayment for Coverage for periods after the effective date of cancellation.

   Cancellation and termination of this Group Subscriber Agreement under this paragraph shall become effective as of the last date of payment. PHP shall be entitled to recover from the Group or from the Subscriber any and all payments made on behalf of any Subscriber or the Subscriber's Dependent(s) after the last date of the period for which Prepayment was received.

2. **Voluntary Termination**. Voluntary termination of Coverage by the Group is governed by the terms of the Group Letter of Agreement. Non-Group Membership Coverage may be terminated by the Subscriber with at least 30 days written notice. Such termination shall only be effective as of the last day of the month.

3. **Termination of Group by PHP**. Termination of the Group by PHP is governed by the terms of the Group Letter of Agreement and is in accordance with Federal and State laws. Termination or cancellation of the Group by PHP shall automatically terminate this Agreement. Upon cancellation or termination by PHP of its Contract with the Group, the Group shall mail promptly a legible copy of the notice of cancellation to each Subscriber at the Subscriber's current address and shall promptly provide to PHP proof of such mailing and the date thereof. Such cancellation shall become effective no sooner than 30 days after the date the notice is mailed to Subscribers. The notice requirement in this paragraph does not apply to any refusal by PHP to renew any Group Letter of Agreement that does not contain an automatic renewal provision or non-payment by the Group.

B. **This Agreement Shall Terminate Automatically for a Member:**

1. On the date specified by PHP, in the case of a Member who refuses to pay any required Copayment for health services rendered, provided that written notice is sent to the Subscriber at least 30 days in advance of such termination. The Member may not re-enroll until the Group's next annual enrollment. However, PHP will not cancel an Enrollee's Coverage for non-payment of Copayments during any period in which a Member is hospitalized and receiving treatment for a life-threatening condition. In addition, PHP will not cancel a Member's Coverage for refusal to follow any prescribed course of treatment.

2. On the date specified by PHP if the Member has knowingly given false material information in connection with the eligibility or enrollment of the Subscriber or any of his/her Dependents; provided that written notice is sent to the Subscriber at least 30 days in advance of such termination. In such case, PHP at its sole discretion may terminate the Subscriber and all of his/her Dependents, and may make such termination effective retroactively as of the date of enrollment. The Subscriber shall be responsible for payment for all services rendered hereunder as of the effective date of such termination and shall reimburse PHP for all such payments made by PHP on behalf of the Subscriber or any of his/her Dependents.

3. On the date of entry into active military duty, except for temporary duty of 30 days or less.

4. At the end of the month in which the Subscriber ceases to physically live or physically work in the Service Area. Coverage for all Covered Dependents will terminate on the same date as the Subscriber's Coverage.

5. At the end of the month in which a Covered spouse ceases to physically live or physically work in the Service Area.

6. At the end of the Contract month or as specified in the Group Letter of Agreement, in which the Member ceases to be eligible as a Subscriber or Dependent; except that with respect to a child placed for adoption whose placement has been disrupted prior to legal adoption, this Contract shall terminate as of the date such child is removed from placement.

7. As of the date on which a Member permits use of his/her PHP Identification Card by any other person, PHP at its discretion may terminate Coverage for such Member and for all Members of his/her family; provided that written notice is sent to the Subscriber at least 30 days in advance of such termination.

8. If two or more Primary Care Physicians, after reasonable effort, are unable to establish and maintain a satisfactory Physician/patient relationship with a Member, then the rights of such Member under this Agreement may be terminated following not less than 30 days written notice to the Member.

9. As of the date specified for refusal to follow PHP's administrative policies or refusal of PHP's benefits; provided that written notice is sent to the Subscriber at least 30 days in advance of such termination.

10. Members terminated for Good Cause are not eligible for COBRA continuation or individual conversion.

C. PHP shall be entitled to recover from the Subscriber any and all payments made on behalf of the Subscriber or the Subscriber's Dependents after the last date the Subscriber's Agreement was in force.

D. PHP may not terminate Coverage under this Agreement for any Member based solely upon the Member's health status, requirements for healthcare service, race, gender, age or sexual orientation, or for refusal to follow a prescribed course of treatment. If a Member believes that Coverage was canceled due to health status or healthcare requirements, the Member may Appeal the cancellation to the Superintendent of Insurance, by mail, Attention: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269; or e-mail at mhcb.grievances@state.nm.us; or fax at **(505) 827-4734.**

E. If PHP terminates or suspends any Contract with a Participating Provider/Practitioner, PHP must notify, in writing, each affected Member who is a current patient or who is assigned to the Participating Provider/Practitioner within 30 days. The notice to Members shall advise each Member of his/her right to continue receiving care from the Participating Provider/Practitioner. PHP shall assist each affected Member in locating and transferring a Member to another similarly qualified Participating Provider/Practitioner. A Member may not be held financially liable for services received from the Participating Provider/Practitioner in good faith between the effective date of the termination or suspension and the receipt of notice provided to the Member, if the Member has not received comparable notice during this time from the Participating Provider/Practitioner.

F. No benefits shall be provided under this Agreement subsequent to the date of termination of this Agreement including, but not limited to, when the Member remains in the Hospital subsequent to the date of termination of this Agreement or unless otherwise agreed to in writing by PHP.

## XIV. CONTINUATION OF COVERAGE

***This section explains options for continuing Coverage for Members who become ineligible for Coverage. This section also addresses a Member's rights if their healthcare Provider/Practitioner leaves the Presbyterian Health Plan (PHP) Provider/Practitioner***

**A. Members whose Coverage would otherwise terminate because of a loss of eligibility may be entitled to continue their Coverage under one of the following options:**

1. Most employer Groups with 20 or more employees are required to offer continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. If a Member is entitled to COBRA Coverage, the Member may continue his or her Coverage as a Member of the Group under this Agreement and in accordance with the Group Letter Agreement for the period of time allowed under COBRA unless and until:

    a. the Subscriber's employer stops offering membership in PHP to its employees;

    b. the Member terminates his or her Coverage;

    c. the Member's Coverage under this Agreement is terminated for Good Cause;

    d. the Member fails to make a timely election for COBRA Coverage;

    e. the Member fails to make timely payments for his or her COBRA Coverage;

    f. the Member becomes Covered under another Group health plan and is not subject to a pre-existing condition clause;

    g. the Member becomes entitled to Medicare benefits; or

    h. the Member lives out of the Service Area.

2. If the Group has fewer than 20 active employees (or is otherwise not required to offer COBRA continuation):

    a. the Subscriber, on behalf of himself and his Dependent(s), upon termination of employment with the Group, has the right to continue his or her Group Coverage for six months under state law, and may thereafter convert his or her Coverage to the individual conversion option provided by PHP in accordance with item B. of this Section; and

b. an enrolled Dependent, upon loss of eligibility for Coverage under this Agreement, may have the option of converting the Group Coverage to the individual conversion option provided by PHP. The circumstances and conditions under which conversion is allowed are specified in item B. of this Section.

c. Coverage under this option will terminate prior to the end of the six-month period of Coverage in the event:

(1) the Subscriber's employer stops offering membership in PHP to its employees;

(2) the Member terminates his or her Coverage;

(3) the Member's Coverage under this Agreement is terminated for Good Cause;

(4) the Member fails to make a timely election for continuation Coverage;

(5) the Member fails to make timely payments for his or her continuation Coverage;

(6) the Member becomes Covered under another Group health plan and is not subject to a pre-existing condition clause;

(7) the Member becomes entitled to Medicare benefits; or

(8) the Member lives out of the Service Area.

3. At the expiration of any continuation period (whether under COBRA or state law), if the Member is still Covered by PHP, the Member will have the option of converting his or her continuation Coverage to the individual conversion option provided by PHP in accordance with the provisions of item B. of this Section.

**B. Conversion to Non-Group Coverage (Individual Conversion Option)**

1. A Subscriber (on behalf of himself and his enrolled Dependents) shall have the right to convert to a separate, Non-Group Contract (called conversion Coverage or Non-Group Coverage) upon termination of the Subscriber's period of continuation.

2. A person enrolled as a Dependent under this Agreement shall have the right to convert to a separate, Non-Group Contract (called conversion Coverage or Non-Group Coverage) upon termination of the Dependent's period of continuation, if any; upon the death of the Subscriber; or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the Subscriber.

Where a spouse of the Subscriber elects conversion Coverage, the Coverage may, at the option of the spouse, include Coverage for Dependent children for whom the spouse has responsibility for care and support.

3. No Member shall have the right to convert to a separate, Non-Group Contract if, at the time of conversion, the Subscriber's Coverage has terminated or will terminate for nonpayment of premium, or non-renewal or expiration of the Group Letter of Agreement.

4. The conversion or Non-Group Coverage provided shall consist of a form of Coverage then being issued by PHP as a conversion Contract. However, if, at the time of conversion, the Member is eligible for Medicare, the right to convert may be limited to Coverage under a Medicare Supplemental Insurance Contract.

5. Conversion Coverage is effective **only if** PHP received the Member's conversion Application and the applicable Prepayment within 31 days after the date the Member's Coverage under this Agreement terminates.

## C. Transition of Care

1. If a Member's healthcare Provider/Practitioner leaves the PHP network, the Member may continue an ongoing course of treatment with that Provider/Practitioner for a transitional period of no less than 30 days.

2. For a Member who is in the third trimester of pregnancy when her Provider/Practitioner leaves the network, the transitional period will include postpartum care directly related to the delivery.

3. This "transitional period rule" does not apply for any Provider/Practitioner who has been terminated from the network for reasons related to medical competence or professional misbehavior.

4. For transitional periods exceeding 30 days, PHP will Certify continued care only if the healthcare provider agrees to:

   a. accept reimbursement from PHP at the rates applicable before the Provider/Practitioner left the network;

   b. adhere to PHP's quality standards and provide PHP with necessary medical information related to such care; and

   c. otherwise adhere to PHP's policies and procedures including, but not limited to procedures regarding Benefit Certification and treatment planning approved by PHP.

5. If, upon the effective date of enrollment, a Member's healthcare Provider/Practitioner is not a Member of the PHP Provider/Practitioner network, the Member may continue an ongoing course of treatment with that Provider/Practitioner as outlined in the transitional period rule described in items 1-4 above.

## D. Extension of Benefits for the Totally Disabled

In the event a Member is Totally Disabled on the date their Group Coverage terminates, health care Coverage may be continued (for the disabling condition only) for up to 12 consecutive months. To claim an extension of benefits, you must notify PHP within 31-days of the Group's Coverage termination date, and provide evidence of your Total Disability.

For purposes of this section, Totally Disabled means that the individual is prevented, solely because injury or disease, from performing their regular or customary occupational duties or is incapable of doing most of the normal activities and tasks for that person's age and family status. In order to qualify for benefits under this extension, a Member must have been Totally Disabled on the date of the Group's termination, incur expense directly resulting from that particular disability and such expense would have been a Covered service before termination.

## XV. PREMIUM PAYMENT

***This section explains how premium payments are to be made to Presbyterian Health Plan (PHP).***

### A. Prepayments (Group)

Prepayments specified in the Group Letter of Agreement are payable in advance by the Group, or the designated Remitting Agent, to PHP at its offices in Albuquerque, New Mexico. The first Prepayment is due and payable on or before the effective date of the Contract. Subsequent Prepayments are due and payable prior to the first day of each month for that month's Coverage, or other period defined by PHP, during the continuation of this Agreement.

### B. Changes in Prepayments

PHP reserves the right to change the Prepayment amount for the Covered Benefits provided under this Agreement as follows:

1. on the annual renewal date of the Agreement or on any monthly date thereafter;

2. on any date that the provisions of the Agreement are amended. Written notice of any such change in Prepayment amount shall be given by PHP to the Group or to the Conversion Subscriber at least 60 days prior to the effective date of the Prepayment change; or

3. as provided in the Group Letter of Agreement.

## XVI. GENERAL PROVISIONS

***This section explains several miscellaneous topics not Covered in other sections of this Group Subscriber Agreement.***

### A. Notice

Any notice required or permitted to be given by Presbyterian Health Plan (PHP) in this Agreement shall be given appropriately if in writing and delivered personally, or deposited in the United States mail with postage prepaid and addressed to the Group, Subscriber or Member at the address of record on file at the principal office of PHP. The Group is solely responsible for ensuring the accuracy of its addresses and the Member is solely responsible for ensuring the accuracy of his/her address of record on file.

### B. Governing Law

This Agreement is made and shall be interpreted under the laws of the State of New Mexico and applicable federal rules and regulations.

### C. Execution of Contract

The parties acknowledge and agree that the Subscriber's signature or execution of the Membership Application form shall be deemed to be his/her acceptance of the Contract, including the Group Letter of Agreement and this Agreement. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void Coverage or reduce benefits unless contained in a written Application for Coverage.

### D. Entire Contract

This Agreement, the Schedule of Benefits, any supplements or riders, the Group Letter of Agreement or the Non-Group Membership Letter of Agreement, the medical questionnaire (if applicable), the Individual Application Form of the Subscriber Covered hereunder and the issued PHP Identification Card constitute the entire Contract between the parties and, as of the effective date hereof, supersede all other Agreements between the parties.

### E. Waiver by Agents

No agent or other person, except an officer of PHP, has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making payment, or to bind PHP by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an endorsement or amendment in writing to this Agreement or the applicable Group or Non-Group Membership Agreement signed by one of the aforesaid officers.

## F. Amendments (Group)

This Agreement and the Group Letter of Agreement shall be subject to amendment, modification, or termination in accordance with their provisions or by mutual agreement in writing between PHP and the Group. By electing Coverage or accepting benefits under this Agreement, all Members legally capable of contracting agree to all the terms, conditions, and provisions of this Agreement, and the Group Letter of Agreement.

## G. Reinstatements

PHP may reinstate this Agreement after termination without the execution of a new Application or the issuance of a new Identification Card or any notice to the Subscriber, other than the unqualified acceptance of an additional payment from the Subscriber or Remitting Agent.

## H. Identification Cards

Identification Cards issued by PHP to Members pursuant to the Group Letter of Agreement are for identification purposes only. Possession of a PHP Identification Card confers no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable Contract charges have actually been paid. Any person receiving services or other benefits to which he/she is not then entitled pursuant to the provisions of the Contract shall be charged therefore at Prevailing Rates. If any Member permits the use of his/her Identification Card by any other person, all rights of such Member and other Members of his/her family pursuant to this Agreement may be immediately terminated at the will of PHP.

## I. Policies and Procedures

PHP may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

## J. Adjustments and Refunds

All requests for Prepayment adjustments and refunds must be filed on forms provided by PHP. Adjustments shall be made in accordance with policies adopted by PHP. When effecting adjustments or refunds, PHP shall not refund any amount involving a period of more than three months prior to the filing of the request.

## K. Member Limitations

It is understood mutually that the number of Members may be limited by PHP.

## L. Assignment

All rights of a Member to receive benefits and services are personal, and may not be assigned.

## M. Workers' Compensation Insurance

This Agreement is not in lieu of and does not affect any requirement for Coverage by the New Mexico Workers Compensation Act. However, an employee of a professional or business corporation may affirmatively elect not to accept the provisions of the New Mexico Workers Compensation Act. More specifically, an employee may waive workers' compensation Coverage provided that the following criteria have been met:

a. the "employee" is an executive officer of a professional or business corporation; and

b. the "employee" owns ten percent (10%) or more of the outstanding stock of the professional or business corporation.

For purposes of the New Mexico Workers Compensation Act, an "executive officer" means the chairman of the board, president, vice-president, secretary or treasurer of a professional or business corporation.

In the event that an employee chooses to opt out of workers' compensation Coverage, and meets the criteria as stated above, PHP will provide 24-hour healthcare Coverage to those employees, subject to the eligibility requirements for Coverage with PHP. In addition to meeting all of PHP's eligibility requirements, documentation indicating that the aforementioned criteria have been met will be required in order for Coverage with PHP to become effective.

## N. Legal Actions

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

## O. Availability of Provider Services

PHP does not guarantee that a Hospital, facility, Physician, or other Provider/Practitioner will be available in the PHP network.

## XVII. GLOSSARY OF TERMS

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

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

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

**AGREEMENT** means this Group Subscriber Agreement, including supplements or riders, if any.

**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 emergency situation.

**ANNUAL GROUP ENROLLMENT PERIOD** means a period of at least ten working days prior to the expiration of each Contract Year agreed to by PHP and the Group, during which eligible Subscribers are given the opportunity to enroll themselves and their eligible Dependents under the Contract without providing evidence of good health satisfactory to PHP.

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

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

**APPLICATION** means the form that each Subscriber is required to complete when enrolling for PHP Coverage.

**BENEFIT CERTIFICATION** means the process whereby PHP or PHP's delegated Provider/Practitioner contractor reviews and approves in advance the provision of certain Covered Benefits to Members before those services are rendered. **If services requiring Benefit Certification are obtained from Non-Participating Providers/Practitioners and Benefit Certification was not obtained, the Member will be responsible for the resulting charges. Services rendered beyond the scope of the Benefit Certification are not Covered.**

**CALENDAR YEAR** means the period beginning January 1, and ending December 31.

**CANCER CLINICAL TRIAL** means a course of treatment provided to a patient for the purpose of prevention of reoccurrence, early detection or treatment of cancer that is being provided in New Mexico.

**CARDIAC REHABILITATION** means the improvement of functions having to do with the heart.

**CERTIFIED NURSE MIDWIFE** means any person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse Midwife.

**CERTIFICATE OF CREDITABLE COVERAGE** means a certificate given to a Member when his/her enrollment from PHP terminates and which states the period of time that the Member was Covered by PHP under a benefit plan for healthcare services. Either the Member's Employer or PHP may be responsible to prepare and deliver the certificate, in compliance with all applicable requirements of state and federal law, to the Member.

**CESSATION COUNSELING** means a program, including individual, Group or proactive telephone quit line, that:

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

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

3. employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities; and

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

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

**COMPLAINT** means the first time PHP is made aware of an issue of dissatisfaction, not complex in nature. For more complex issues of dissatisfaction see definition for Grievance.

**CONTRACT** means the Application submitted as the basis for issuance of this Group Subscriber Agreement. This Group Subscriber Agreement including the Schedule of Benefits, any supplements or riders, the medical questionnaire (if applicable), the issued Identification Card, and the applicable Group Letter of Agreement or Non-Group Membership Letter of Agreement constitute the entire Contract.

**CONTRACT YEAR** means the period, or other length of time Covered by the Contract, agreed to by PHP and the Group, as specified in the Group Letter of Agreement.

**CONVERSION SUBSCRIBER** means a Member who has converted to non-Group Membership in PHP as a Subscriber, pursuant to Section XIV. (Continuation of Coverage) item B. of this Agreement.

**COPAYMENT** means the amount required to be paid by a Member directly to the Provider/Practitioner in connection with healthcare services. If the charged amount for the medical or pharmacy services provided to you is less than your Copayment amount, then you pay the lesser amount.

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

**COVERAGE/COVERED OR COVERED BENEFITS** means benefits extended under this Agreement, subject to the terms, conditions, limitations, and exclusions of this Agreement.

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

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

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

**CYTOLOGIC SCREENING** (PAP Smear) means a Papanicolaou test and a pelvic exam for symptomatic as well as asymptomatic female patients.

**DEDUCTIBLE** means the amount required to be paid for each Calendar Year by a Member directly to the Provider in connection with healthcare services before health benefits are paid.

**DEPENDENT** means any Member of a Subscriber's family who meets the requirements of Section VIII. (Eligibility, Enrollment and Effective Dates) item A. (Who is Eligible?) of this Agreement is enrolled hereunder, and for whom the Prepayment has been actually received by PHP.

**DIAGNOSTIC SERVICE** means procedures ordered by a Physician or Provider/Practitioner 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 Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

**ELECTIVE HOME BIRTH** means a birth that was planned or intended by the Member or Provider/Practitioner to occur in the home.

**EMERGENCY HEALTH SERVICES** means healthcare procedures, treatments, or services delivered to a Covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

1. jeopardy to the person’s health;

2. serious impairment of bodily functions;

3. serious dysfunction of any bodily Organ or part; or

4. disfigurement to the person.

**ENROLLEE** means anyone who is entitled to receive healthcare benefits provided by PHP.

**EXPERIMENTAL OR INVESTIGATIONAL** refer to Section VII. (Exclusions) of the Agreement.

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

**FAMILY, INFANT AND TODDLER (FIT) PROGRAM** means an early intervention services program provided through the Family, Infant and Toddler program to eligible children and their families in accordance with that which is required under N.M.S.A. **§ 59A-46-38.1**.

**FDA** means the United States Food and Drug Administration.

**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:

1. disorders of protein metabolism (i.e. amino acidopathies such as PHU, organic acidopathies, and urea cycle defects); or

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

3. disorders of fat metabolism.

**GOOD CAUSE** means nonpayment of premium, fraud or a cause for cancellation or a failure to renew which the Superintendent of Insurance of the State of New Mexico has not found to be objectionable by regulation.

**GRIEVANCE** means any expression of dissatisfaction from any Member, Provider/Practitioner or their representative.

**GROUP** means the legal entity, which has contracted with PHP to obtain the benefits, described in this Agreement for Subscribers and eligible Dependents in return for periodic Prepayments specified in the Group Letter of Agreement.

**GROUP LETTER OF AGREEMENT** means the administrative Agreement between PHP and the Group.

**GROUP SUBSCRIBER AGREEMENT** means the booklet which describes the benefits for which the Member and his/her eligible Dependents (if any) are eligible for under the terms of the employer's Contract.

**HOME HEALTH AGENCY** means a facility or program which is licensed, certified or otherwise authorized pursuant to the laws of the State of New Mexico as a Home Health Agency and which has entered into an Agreement with PHP or has been approved by PHP in advance to provide Covered Benefits to PHP Members.

**HOSPICE** means a duly licensed facility or program, which has entered into an Agreement with PHP to provide healthcare services to Members who are diagnosed as terminally ill.

**HOSPITAL** means an acute care general Hospital, which:

1. has entered into an Agreement with PHP to provide Covered Hospital services to PHP Members; and

2. provides Inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed Physicians; and

3. is not, other than incidentally, a place for rest, a place for the aged, or a nursing home; and

4. is duly licensed to operate as an acute care general Hospital under applicable state or local law.

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

**IDENTIFICATION CARD or ID CARD** means that card issued to a Subscriber upon approval of an Application by PHP.

**IMMUNOSUPPRESSIVE DRUGS** 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. "autoimmune" diseases);

4. reducing inflammation;

5. relieving certain symptoms; and

6. other times when it may be helpful to suppress the human immune response.

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

**INVESTIGATIONAL OR EXPERIMENTAL** refer to Section VII. (Exclusions) of this Agreement.

**LICENSED MIDWIFE** means a person who has successfully completed all the requirements for New Mexico Licensed Midwifery and is in good standing with the Public Health Division. Licensed Midwives must follow midwifery protocols in accordance with the *"Standards and Core Competencies of Practice for Licensed Midwives in New Mexico"* and the *"New Mexico Midwives Association: - Practice Guidelines."*

**LIFETIME MAXIMUM** means the maximum dollar amount PHP will pay for a particular benefit during the lifetime of a Member under this Group Subscriber Agreement.

**LONG-TERM THERAPY OR REHABILITATION SERVICES** Therapies are considered Long-term if the Member's Physician, in consultation with PHP, does not believe Significant Improvement is likely to occur within two months. Long-Term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down's Syndrome and Cerebral Palsy.

**MAINTENANCE MEDICATIONS** means a medication taken regularly such as on a daily or monthly basis in order to maintain the Member's health.

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

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

**MATERNITY** means Coverage for prenatal, intrapartum, perinatal or postpartum care.

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

**MEDICAL NECESSITY OR MEDICALLY NECESSARY** means appropriate or necessary services as determined by a Participating Provider/Practitioner in consultation with PHP, which are provided to a Member for any Covered condition requiring, according to generally accepted principles of good medical practice guidelines developed by the federal government, national or professional medical societies, boards, and associations, or any applicable clinical protocols or practice guidelines developed by PHP consistent with such federal, national and professional practice guidelines, for the diagnosis or direct care and treatment of an illness, injury, or medical condition, and are **not** services provided only as a convenience.

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

**MEMBER** means the Subscriber or Dependent eligible to receive services for Covered Benefits under this Group Subscriber Agreement.

**NON-PARTICIPATING PROVIDER/PRACTITIONER** means a healthcare Provider/ Practitioner, including medical facilities, who has not entered into an Agreement with PHP to provide healthcare services to PHP Members.

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

**OBSERVATION SERVICES** means outpatient services furnished by a Hospital and Provider/Practitioner on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Providers/Practitioners written order. To transition from observation to an Inpatient admission level of care criteria used by PHP must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

**OBSTETRICIAN/GYNECOLOGIST** means a Physician who is board eligible or board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

**OPTIONAL BENEFIT RIDER** means additional Coverage for certain benefits that can be purchased by an employer who qualifies for Optional Benefit Riders. These riders offer additional Coverage for certain services such as Prescription Drugs and/or Alcohol/Substance Abuse rehabilitation services.

**ORGAN** means an independent body structure that performs a specific function.

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

**ORTHOTIC APPLIANCE** means an external device intended to correct any defect of form or function of the human body.

**OUT-OF-NETWORK** means services obtained from a Non-Participating Provider/Practitioner as defined above.

**OVER-THE-COUNTER (OTC)** means a drug for which a prescription is not normally needed.

**PHP** means Presbyterian Health Plan, Inc., a corporation organized under the laws of the State of New Mexico.

**PARTICIPATING PHARMACY** means any duly licensed pharmacy, which has entered into an Agreement with PHP to dispense prescribed drugs to PHP Members.

**PARTICIPATING PHYSICIAN** means any duly licensed Provider/Practitioner of the healing arts acting within the scope of his/her license who has entered into an Agreement directly with PHP to provide healthcare services to PHP Members.

**PARTICIPATING PROVIDER/PRACTITIONER** means any duly licensed individual or institutional Provider of healthcare services, which has entered into an Agreement directly with PHP to provide healthcare services to PHP Members.

**PERSONAL REPRESENTATIVE** means a parent, guardian, or other person with legal authority to act on behalf of an individual in making decisions related to health care.

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

**PHYSICIAN** means any duly licensed Provider/Practitioner of the healing arts acting within the scope of his/her license.

**PREFERRED DRUG LIST** means a list of drugs approved for Coverage under this Group Subscriber Agreement and will indicate at which tier level a drug is Covered. PHP's Pharmacy and Therapeutics Committee continually update this listing. A copy of this listing is available on our website at www.phs.org or by calling PHP's Member Services Department at **(505) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD **(505) 923-5699,** TTY/TDD toll-free **(877) 298-7407**.

**PREPAYMENT** means the monthly amount of money charged by PHP and payable in advance for benefits provided under this Group Subscriber Agreement in accordance with the applicable Group Letter of Agreement or Non-Group Membership Letter of Agreement.

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

**PREVAILING RATE** means the rates generally charged in PHP's Service Area for medical, surgical, Hospital and related healthcare services.

**PRIMARY CARE PHYSICIAN** means a healthcare Provider/Practitioner approved by PHP and formally selected by the Member who supervises, coordinates, and provides initial and basic care to Members, who initiates their referral for specialist care, and who maintains continuity of patient care. PHP designates Providers/Practitioners to be Primary Care Physicians, provided they:

1. provide care within their scope of practice as defined under the relevant state licensing law;
2. meet PHP's eligibility criteria for healthcare Providers/Practitioners who provide Primary Care; and
3. agree to participate and to comply with PHP's care coordination and referral policies.

Primary Care Physicians includes, but is not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). A list of Practitioners who serve as Participating Primary Care Physicians may be found in the PHP Provider Directory.

**PROSTHETIC DEVICE** means an artificial device to replace a missing part of the body.

**PROVIDER/PRACTITIONER** means any duly licensed institutional Provider of healthcare services or individual who provides services to PHP Members.

**PULMONARY REHABILITATION** means a program of therapy designed to improve lung functions.

**REASONABLE CHARGE or REASONABLE AND CUSTOMARY CHARGE** means the amount determined to be payable by PHP for services rendered to Members by Non-Participating Providers/Practitioners, based upon the following criteria:

1. the PHP fee schedule for the services provided;

2. fees that a professional Provider/Practitioner usually charges for a given service;

3. fees which fall within the range of usual charges for a given service filed by most professional Providers/Practitioners in the same locality who have similar training and experience; and

4. fees which are usual and customary or which could not be considered excessive in a particular case because of unusual circumstances.

**RECONSTRUCTIVE SURGERY** means the following:

1. surgery to correct a physical functional disorder resulting from a disease or congenital anomaly;

2. surgery to correct a physical functional disorder following an injury or incidental to any surgery; and

3. Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

**REHABILITATION FACILITY** means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

**REMITTING AGENT** means the person or entity designated by the Group to collect and remit the Prepayment to PHP.

**RESIDENTIAL TREATMENT CENTER** means a non-acute level facility credentialed and contracted with PHP that provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available 24 hours a day.

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

**SERVICE AREA** means the geographic area in which PHP is authorized to provide services as a Health Maintenance Organization and includes the entire state of New Mexico with the exception of southern Eddy County. The Service Area is depicted on Exhibit A. The area may be changed by PHP by written notice to the Member or Group.

**SHORT-TERM REHABILITATION** means rehabilitation and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected within two months from the date therapy first begins.

**SIGNIFICANT IMPROVEMENT** means that:

1. the patient is likely to meet all therapy goals for the first two months of therapy; or

2. the patient has met all therapy goals in the preceding two months of therapy, as specifically documented in the therapy record.

**SKILLED NURSING FACILITY** means an institution which is licensed under state law to provide skilled care nursing services and which has entered into an Agreement with PHP to provide Covered Benefits to PHP Members.

**SMOKING CESSATION COUNSELING/PROGRAM** means a program, including individual, group, or proactive telephone quit line, that:

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

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

3. employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities; and

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

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

1. formulated to be consumed or administered internally under the supervision of a Physician and prescribed by a Physician;

2. specifically processed or formulated to be distinct in one or more nutrients present in natural food;

3. intended for the medical and nutritional management of Members with limited capacity or metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

4. essential to optimize growth, health and metabolic homeostasis.

**SPECIALTY PHARMACEUTICALS** means

1. Oral or inhalation forms of Specialty Pharmaceuticals (deemed Part D by Medicare) are those which can be administered on a routine basis by a patient or family member at home. Oral or inhalation forms of Specialty Pharmaceuticals are subject to the Tier 4 Copayment and may be subject to Benefit Certification.

2. Self-administered Specialty Pharmaceuticals (deemed Part D by Medicare) are defined as those which are administered more often than once a month by a patient or family member at home, are administered subcutaneously or intramuscularly and considered safe for self administration by PHP's Pharmacy and Therapeutics Committee. Self-administered Specialty Pharmaceuticals must be obtained through a designated specialty pharmacy vendor, are subject to the Tier 4 Copayment and may be subject to Benefit Certification.

3. Intravenous (IV) Specialty Pharmaceuticals (for example, those medications administered into the vein in conjunction with a physician office visit and deemed Part B by Medicare) are not considered self-administered Specialty Pharmaceuticals. Intravenous (IV) Specialty Pharmaceuticals are not subject to the Tier 4 Copayment and may be subject to Benefit Certification.

   This listing is continually updated by PHP's Pharmacy and Therapeutics Committee. A copy of this listing is available on our website at www.phs.org or by calling PHP's Member Services Department at **(505) 923-5678** or toll-free at **1-800-356-2219** or TTY/TDD **(505) 823-5699,** TTY/TDD toll-free **(877) 298-7407**.

**STUDENT** means a person attending an accredited college or university, trade or secondary school.

**SUBLUXATION (CHIROPRACTIC)** means misalignment, demonstrable by x-ray or chiropractic examination, which produces pain and is correctable by manual manipulation.

**SUBSCRIBER** means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment with PHP or in the case of an individual Contract, the person in whose name the Contract is issued.

**SUBSTANCE ABUSE** means dependence or abuse of substances meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

**TEMPOROMANDIBULAR JOINT (TMJ)** is the joint that hinges the lower jaw (mandible) to the temporal bone of the skull.

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

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

**TOTAL ALLOWABLE CHARGES** means, for Participating Providers/Practitioners, the Total Allowable Charges may not exceed the amount the Provider/Practitioner has agreed to accept from PHP for a service and for Non-Participating Providers/Practitioners, the Total Allowable Charges may not exceed the Reasonable and Customary Charge as determined by PHP for a service.

**URGENT CARE** means Medically Necessary healthcare services provided in emergencies or after a Primary Care Physician's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

**URGENT CARE CENTER** means a facility operated to provide healthcare services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

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

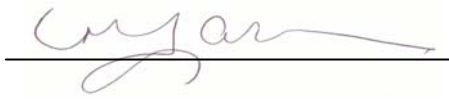
**WELL CHILD CARE** means routine pediatric care and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

**WOMEN'S HEALTHCARE PROVIDER/PRACTITIONER** means any Participating Physician who specializes in women's health and is recognized as a Women's Healthcare Provider/Practitioner by PHP.

This Group Subscriber Agreement is issued to the Group for the Subscriber named in an Application received and accepted by Presbyterian Health Plan, Inc., a New Mexico corporation. The terms and conditions appearing herein and any applicable amendments are part of this Group Subscriber Agreement.

IN WITNESS THEREOF, Presbyterian Health Plan, Inc., has caused this Group Subscriber Agreement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN, INC.

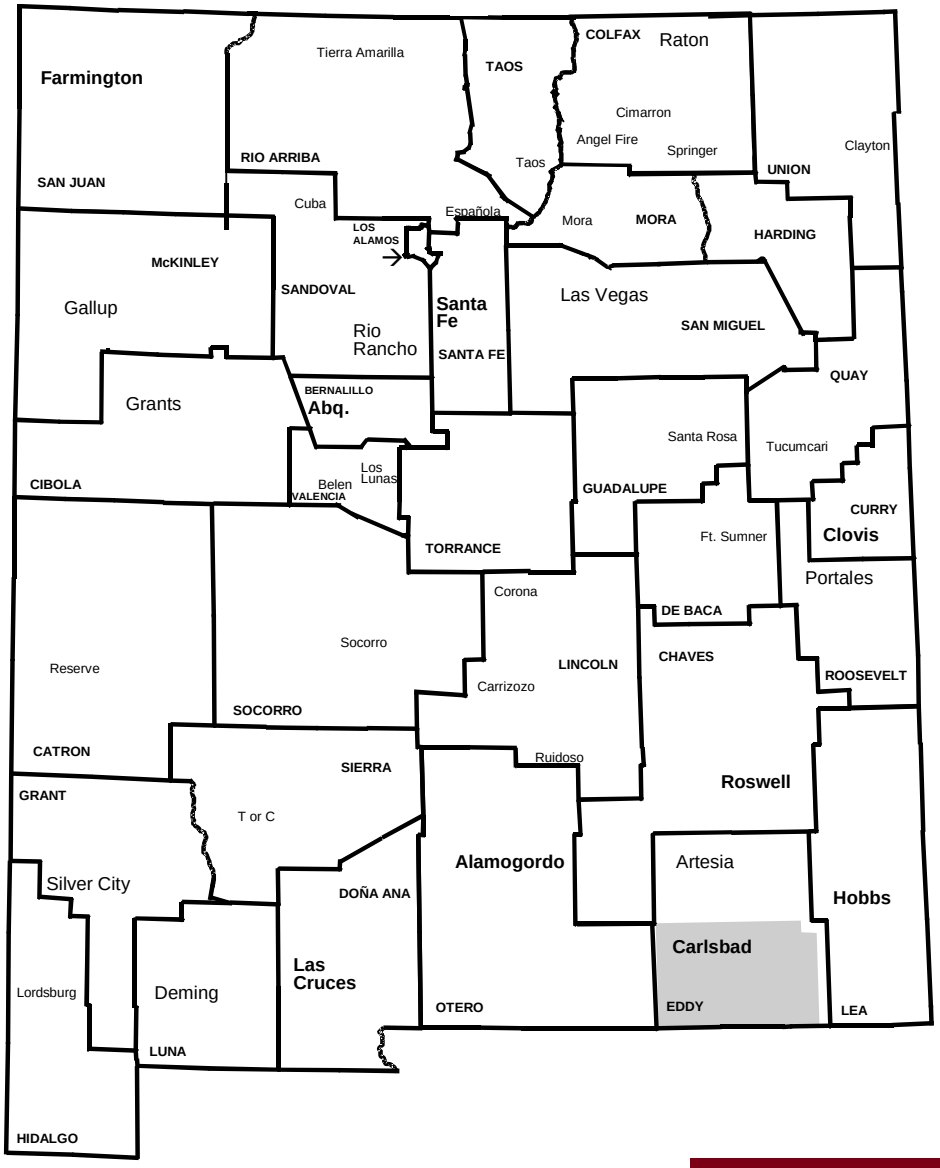


Lisa Farrell
Vice President & Chief Financial Officer
Presbyterian Health Plan

# EXHIBIT A

**Service Area Map**

PRESBYTERIAN Health Plan




**New Mexico**

**Legend**

| |
|---|
| Managed Care Service Area |
| Not included in Managed Care Service |

**EXHIBIT B**

## Statement of ERISA Rights

The Group health care Coverage provided by your employer may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The statement of ERISA rights is applicable to all Group plans except governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens.

If applicable, as a participant in your employer's Group health care plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants be entitled to:

### Receive Information about your Plan and Plan Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

### *Continue Group Health Plan Coverage*

Continue health care Coverage for yourself, spouse or Dependents if there is a loss of Coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such Coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation Coverage rights. Reduction or elimination of exclusionary periods of Coverage for pre-existing conditions under your Group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your Group health plan or health insurance issuer when you lose Coverage under the plan, when you become entitled to elect COBRA continuation Coverage, when your COBRA continuation Coverage ceases, if you request it before losing

Coverage, or if you request it up to 24 months after losing Coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late Enrollees) after your enrollment date in your Coverage.

***Prudent Actions by Plan Fiduciaries***

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining health care benefits or exercising you rights under ERISA.

***Enforce Your Rights***

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

***Assistance With Your Questions***

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (listed in your telephone directory), or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor (200 Constitution Avenue, N.W., Washington, D.C. 20210). You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

# Memorandum

**To:** Presbyterian Customer Service Center

**CC:** John Johnson, David Nater, Tamura Casados, Troy Samora

**From:** Health Plan Benefits Administration

**Date:** 09/24/2009

**Re:** Eye Care for Diabetes Members

---

This memo is to clarify eye care benefits for members with diabetes. Eye exams related to medical conditions are covered benefits.

Examples of Medical conditions include, but are not limited to:

| | |
|---|---|
| Diabetic Retinal Exams | Keratoconus |
| Eye infections | Eye Hemorrhage |
| Eye Injury | Hypertension |
| Eye Pain | Neurological eye disorder |
| Glaucoma | Optic nerve problems |
| Iritis | Retinal detachment |

Please note: Members will need to see a Contracted Medical Eye Care Provider listed in the Provider Directory under Optometry and Ophthalmology for service.

For more information, refer to the Vision Care Benefit Topic under the Benefit Interpretation Manual and/or the Vision job aid under Claims in DART.

| **Subject: Physician and Specialist Services** | **Page 1 of 4** |
|---|---|
| **Services: Vision Care** | |

***Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans.***

## A. DEFINITION

Vision Care - Treatment related to conditions of the eye.
Aphakic - Without a lens (members who have had cataract surgery without an intraocular lens implant.)
Refraction - Determination of the amount of ocular focus errors and their correction.
Eye exam - Internal and external inspection of the eye with light to determine the existence of a medical condition of the eye.

## B. INTERPRETATION

Benefits are available for treatment of medical conditions or symptoms of the eye. Treatment that is considered routine vision care is not covered under most plans. Referrals should not be given for treatment that is not covered under the member's plan.

*Ophthalmologists vs. Optometrists*

- Ophthalmologists can treat all conditions of the eye and can prescribe medication. In addition, they can perform surgery.
- Optometrists can treat certain conditions of the eye, and prescribe medication for them. However, they cannot perform surgery.

**Key Points**

1. Eye exams related to medical conditions are covered. Examples of medical conditions include, but are not limited to:

| | |
|---|---|
| Diabetic Retinal Exams | Eye Hemorrhage |
| Eye infections | Hypertension |
| Eye injury | Neurological eye disorder |
| Eye Pain | Optic nerve problems |
| Glaucoma | Retinal detachment |
| Iritis | Headache (workup by PCP assumed, |
| Keratoconus | including preliminary vision screening to rule out myopia, etc.) |

2. Routine vision screenings done by the PCP to determine the need for vision correction is covered. This type of exam would normally include having the member read the eye chart.

| **Subject: Physician and Specialist Services** | **Page 2 of 4** |
|---|---|
| **Services: Vision Care** | |

3. Glaucoma eye tests for persons 35 or older are covered. Usually done by an optometrist or ophthalmologist.
4. Up to 1 refraction per year for children under 6 years of age are covered for the following diagnoses:

| | |
|---|---|
| 362.21 | Retrolental fibroplasia |
| 362.74 | Pigmentary retinal dystrophy |
| 363.32 | Other macular scars |
| 366.02 | Infantile, juvenile and presenile posterior subcapsular polar cataract |
| 368.00 | Amblyopia unspecified |
| 368.01 | Strabismic amblyopia |
| 368.02 | Deprivation amblyopia |
| 368.03 | Refractive amblyopia |
| 368.2 | Diplopia |
| 371.02 | Peripheral opacity of cornea |
| 377.10 | Optic atrophy, unspecified |
| 377.11 | Primary optic atrophy |
| 377.12 | Post-inflammatory optic atrophy |
| 377.75 | Cortical blindness |
| 378.01 | Monocular esotropia |
| 378.05 | Alternating esotropia |
| 378.11 | Monocular exotropia |
| 378.15 | Alternating esotropia |
| 378.22 | Intermittent esotropia, alternating |
| 378.23 | Intermittent exotropia, monocular |
| 378.24 | Intermittent exotropia, alternating |
| 378.35 | Accommodative component in esotropia |
| 378.41 | Esophoria |
| 378.42 | Exophoria |
| 378.51 | Third or oculomotor nerve palsy, total |
| 378.53 | Fourth or trochlear nerve palsy |
| 378.54 | Sixth or abducens nerve palsy |
| 378.61 | Brown's (tendon) sheath syndrome |
| 378.71 | Duane's syndrome |
| 783.40 | Lack of normal physiological development, unspecified |
| V71.9 | Observation for unspecified suspected condition |

5. Contact lenses for the correction of keratoconus, and acute or chronic corneal pathology are covered. This includes the related eye exam and refraction.
6. Corrective lenses when related to Genetic Inborn Errors of Metabolism are covered.
7. A standard **Intraocular Lens** that provides for distance vision is covered following cataract surgery. If members choose a lens that is multifocal, such as the ReStor Multifocal Intraocular Lens, PHP/PIC will provide reimbursement up to the amount of the standard lens. The member will be responsible for the additional cost. These multifocal IOLs are a deluxe item and are not considered medically necessary.

| **Subject: Physician and Specialist Services** | **Page 3 of 4** |
|---|---|
| **Services: Vision Care** | |

8. One pair of standard (non-tinted) eyeglasses (or contact lenses if visual acuity is not possible with glasses) is covered within 12 months after cataract surgery. This includes the eye refraction, exam, lenses and standard frames.
9. The Prosthetic/Orthotic copay applies for covered eyeglasses, lenses and contacts.
10. Laser surgery as a treatment for retinal detachment, hemorrhage and non-refractive purposes is covered.

## C. NOT COVERED

1. Eye exams and refractions for Errors of Refraction. The following diagnoses are considered Errors of Refraction:
   Hyperopia (far-sighted)
   Myopia (near-sighted)
   Astigmatism
   Ametropia
   Emmetropia (This is the term for an eye with no refractive errors, or a normal eye.)
2. Eye refraction (code 92015) except as specified as covered in paragraphs 5, 6, and 8 above.
3. Exam and refraction for dyslexia.
4. Eyeglasses, sunglasses, frames, lens prescriptions, contact lenses or the fitting of visual aids except as noted above.
5. Routine exams and refractions for determining eyeglass or contact lens prescriptions.
6. Radial keratotomy, Lasik, laser surgery and other techniques for vision correction.
7. Visual Training

## D. REFERENCES

New Mexico Administrative Code, Title 13: Insurance, Chapter 10: Health Insurance, Part 13: Managed Health Care, Rule § F. Children's Health Care, 2. Vision testing for persons through age 17 to determine the need for vision corrections.

New Mexico Administrative Code, Title 13: Insurance, Chapter 10: Health Insurance, Part 13: Managed Health Care, Rule § H. Health Promotion Program, 2. Glaucoma eye tests for persons 35 or older in accordance with US Preventive Services Task Force.

| **Subject: Physician and Specialist Services** | **Page 4 of 4** |
|---|---|
| **Services: Vision Care** | |

Date Approved by BDIC: February 28, 2000

Date(s) Revised by BDIC: September 23, 2002, September 29, 2003, January 23, 2006

# Memo

To: Member Services

From: Sandra Goodman-Padilla

CC: DART

Date: June 14, 2007

Re: Outpatient SA Visit Correction

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This memo is to clarify that all products with the Substance Abuse benefit, including Substance Abuse riders should have a 30 visit limit for outpatient services mandated by the Department of Insurance. Currently our member materials indicate 20 visits.

Member materials are being corrected and there are some PIC plans that are configured incorrectly with the 20 visit limit. Member materials have been corrected going forward. An SMR has been submitted to correct the plans that are showing the incorrect visit limit. This should be completed by the end of June.

Should you have questions, please contact me at ext. 5419. Thank you!

/sgp

PRESBYTERIAN

Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489
(505) 923-5700
www.phs.org

*Para recibir información en español sobre el contenido de esta planilla, sírvase llamar al Departamento de servicios para los Miembros del Plan al (505) 923-5678, o al 1-800-356-2219.*

May 1, 2007

Dear Presbyterian Health Plan Member:

Thank you for your membership with Presbyterian Health Plan. Presbyterian's purpose is to improve the health of individuals, families and communities, and we continually look for ways to better serve our members. As a valued member of our health plan, we are pleased to share some important information with you about an exciting enhancement to your medical coverage.

Effective May 1, 2007, your medical plan will cover online "web visits" with your Primary Care Physician or other practitioners. The enclosed endorsement details your coverage, including the low co-payment amount for this service on your particular plan. It is important to note that not all Presbyterian Health Plan providers are participating in this service at this time. **Visit www.phs.org/e-care for an up-to-date list of providers participating in this service.**

**More good news: Pres e-Care**
Presbyterian Health Plan and Presbyterian Medical Group are partnering to offer Pres e-Care, a web-based physician-patient communication, which allows their patients to manage their health care online. Pres e-Care connects Presbyterian Medical Group patients with their physicians so they can talk with each other and proactively monitor their patients' health online. To benefit from this new service, Presbyterian Medical Group patients need to complete a free registration for this program (see page 2 for instructions). If your provider has chosen to participate in this service, you can begin using it immediately.

Presbyterian Medical Group patients who use Pres e-Care can enhance their healthcare experience in several powerful ways:

**Communicate with your physician's office – online – any time**
Take advantage of Pres e-Care services for routine communication with your physician's office – when and where it's convenient for you. You may request appointments, lab results, and prescription renewals and refills – all from the convenience of your home or office computer.

You can also communicate with your physician about non-urgent symptoms when it's most convenient for you – all you need is an internet connection. The webVisit® guides you through an interactive interview, and builds a concise message to your physician. You'll receive an answer directly from your physician. You can access sent and received messages at any time for easy, online reference. And, your privacy is protected. Pres e-Care has stronger privacy and security compared to regular e-mail or the telephone.

**Convenience**
Don't have time to wait on hold? Can't wait for the physician's office to open? Save time by using Pres e-Care.

**Cost**
There is no charge for routine communications, such as appointment requests. The webVisit® requires a co-payment or out-of-pocket fee.

**Privacy**
Pres e-Care uses secure technology. Only you, your physician, and your physician's authorized staff have access to your information.

The following Presbyterian Medical Group offices now offer Pres e-Care. For an up-to-date list, go to www.phs.org/e-care.

- 609 S. Christopher Dr. Belen
- 200 Emilio Lopez Rd. Los Lunas
- 8800 Montgomery Blvd. NE
- 3436 Isleta Blvd. SW
- Kaseman Family Healthcare
- Kaseman Adult Healthcare Clinic
- 5901 Harper NE
- 3901 Atrisco NW
- 4005 High Resort Blvd, Rio Rancho
- 4100 High Resort Blvd, Rio Rancho
- 401 San Mateo Blvd SE
- 5550 Wyoming Blvd. NE

The following locations will offer Pres e-Care in the next few weeks and months:

- Sleep Disorders Center
- Ruidoso Outpatient Clinics
- Socorro
- Presbyterian Heart Group
- Española Multi-Specialty Clinic
- Plains Regional Medical Center, Clovis
- Presbyterian Medical Group Specialists Clinics

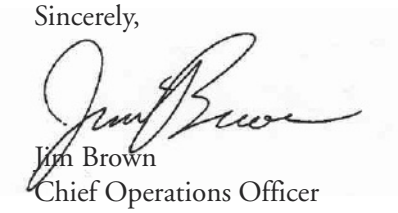
**Sign up today so it's available to you when you need it**
Visit www.phs.org and click on "Visit Presbyterian Online" from the Home Page. Next, click on "Talk to your physician or provider online." It's quick and easy to register for Pres e-Care. Again, there is no charge for routine communications, such as appointment requests, lab results, and medication refill requests. The webVisit® requires a co-payment or out-of-pocket fee. Refer to the attached endorsement for the co-payment amount for your plan.

We hope you'll take advantage of this exciting new program. We want you to enjoy a convenient new way to access your physician and save time in the process.

We value your participation as a member of our health plan and encourage you to be an active member of your healthcare team by being an informed consumer. If you have any questions, please contact a Presbyterian Member Services Representative via e-mail at info@phs.org. You may also call (505) 923-5678 or toll free at 1-800-356-2219. Presbyterian Member Services Representatives are available Monday through Friday from 7 a.m. to 6 p.m. to assist you.

We look forward to serving your healthcare needs.

Sincerely,



Jim Brown
Chief Operations Officer
505-923-5925
Jbrown4@phs.org
*Another member of Presbyterian working to improve your health.*

*Do you have access to the Internet? Check out A.D.A.M., our health information database, on www.phs.org, for reliable health information, detailed medical illustrations and interactive health tools. A.D.A.M. has the answers to many of your health questions.*

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**Smart Care HMO Large and Small Group**

**ENDORSEMENT REGARDING - 2007 Commercial Benefit Mandates**

**Effective 6/15/07**

All terms, benefits, exclusions and provisions of the Group Subscriber Agreement and/or Schedule of Benefits not specifically amended by this Endorsement shall remain in full force and in effect.

**Section IV. Benefits, item D. Clinical Preventive Services, and item I. Durable Medical Equipment of the Group Subscriber Agreement – The following language regarding *Hearing Aids* has been amended and will now read as follows:**

**D. Clinical Preventive Services**

3. Vision and Hearing Screening performed only by the PCP to determine the need for vision and hearing correction. This does not include routine eye exams or Eye Refractions performed by eye care specialists. One Eye Refraction per Calendar Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases. **Hearing aids and the evaluation for the fitting of hearing aids is not Covered except for school aged children under 18 years old (or under 21 years of age if still attending high school).**

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

7. Hearing Aids

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

a. Up to $2,200 every 36 months "per hearing impaired ear" for school aged children under 18 years old (or under 21 years of age if still attending high school).

b. Shall include fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by a Participating Provider/Practitioner licensed in New Mexico.

**Section IV. Benefits, item V. Rehabilitation and Therapy of the Group Subscriber Agreement – The following language regarding *Hearing Aids* has been amended and will now read as follows:**

**V. Rehabilitation and Therapy**

4. Outpatient Speech Therapy**.**

g. Hearing aid evaluations are **not Covered except for school aged children under 18 years old (or under 21 years of age if still attending high school)**.

**Section VII. Exclusions, item AH. Hearing Aids of the Group Subscriber Agreement – The following language regarding *Hearing Aids* has been amended and will now read as follows:**

**VII. Exclusions:**

AH. **Hearing aids** and the evaluation for the fitting of hearing aids **except for school aged children under 18 years old (or under 21 years of age if still attending high school)**.

**Section XVII. Glossary of the Group Subscriber Agreement – The following definition has been added regarding *Hearing Aids*:**

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

**The following language located in the Schedule of Benefits regarding Hearing Aids has been added and will read as follows:**

| | **Copayment** |
|---|---|
| **DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[(1)]**<br>• **Hearing Aids (for school aged children under age 18 or 21 years of age if still attending high school)** | **Refer to Schedule of Benefits for Copayment Amount.**<br>**Up to $2,200 every 36 months "per hearing impaired ear".** |

**The following language located in the Exclusions section of the Schedule of Benefits regarding *Hearing Aids* has been amended and will read as follows:**

- **Hearing aids** and the evaluation for the fitting of hearing aids **except for school aged children under 18 years old (or under 21 years of age if still attending high school)**.

**Section IV. Benefits, item D. Clinical Preventive Services of the Group Subscriber Agreement – The following language regarding *Colorectal Cancer Screenings* has been amended and will now read as follows:**

**D. Clinical Preventive Services**

5. Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:

   a. Fecal occult blood testing (FOBT),

   b. Flexible Sigmoidoscopy,

   c. Colonoscopy,

   d. Double contrast barium enema.

**Section IV. Benefits, item D. Clinical Preventive Services and item Z. Women's Healthcare of the Group Subscriber Agreement – The following language regarding *Coverage of HPV Vaccine* for females aged nine to 14 years of age has been added and will now read as follows:**

**D. Clinical Preventive Services**

11. HPV Vaccine Coverage for the Human Papillomavirus, as approved by the Food and Drug Administration, for females nine to 14 years of age used for the prevention of Human Papillomavirus infection and cervical pre-cancers. In addition, the HPV vaccine is covered for other populations ***in accordance with guidelines established by*** The Advisory Committee on Immunization Practices (ACIP).

**Z. Women's Healthcare**

6. Cytologic Screening (PAP Smear), Human Papillomavirus (HPV) screenings, HPV Vaccine coverage for females nine to 14 years of age and other populations ***in accordance with guidelines established by*** The Committee on Immunization Practices (ACIP), and mammography Coverage described in Section IV. (Benefits) item D. (Clinical Preventive Services).

**IN WITNESS THEREOF, Presbyterian Health Plan, Inc. has caused this Group Subscriber Agreement/Schedule of Benefits Endorsement to be executed by a duly authorized agent.**

PRESBYTERIAN HEALTH PLAN, INC.

_____

Lisa Farrell
Treasurer
Presbyterian Health Plan, Inc.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**PHP Custom/Value Care HMO**
**PHP My Care Active/Family**
**PHP Smart Care (Large and Small)**
**PHP Alliance Group/Individual**

## ENDORSEMENT REGARDING - 2007 Commercial Benefit Mandate Regarding Health Insurance Coverage for General Anesthesia and Hospitalization for Dental Surgery

**Effective 7/1/07**

All terms, benefits, exclusions and provisions of the Group/Subscriber Agreement and/or Schedule of Benefits not specifically amended by this Endorsement shall remain in full force and in effect.

**Section IV. Benefits, item E. Dental Services of the Subscriber Agreement – The following language regarding *General Anesthesia and Hospitalization for Dental Surgery* has been amended and will now read as follows:**

**F. Dental Services Including Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)**

5. **Hospitalization, day surgery, outpatient services and/or anesthesia for Non-Covered dental services, are Covered if,** provided in a hospital or ambulatory surgical center for dental surgery when approved by PHP. Plan benefits for these services include coverage:

   a. for Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;

   b. for Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

   c. for Covered children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

   d. for Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; and

   e. for *other procedures* for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

**Section VII. Exclusions, item X.1. Dental care of the Subscriber Agreement – The following language regarding *General Anesthesia and Hospitalization for Dental Surgery* has been amended and will now read as follows:**

**VII. Exclusions relating to Dental Services:**

**X.1** **Dental care and** dental x-rays, except as provided in Section IV. (Benefits) item F. (Dental Services/TMJ/CMJ), hospitalization, day surgery, outpatient services and/or anesthesia for Non-Covered dental services **are covered if provided in a hospital or ambulatory surgical center for dental surgery when approved by PHP.**

**IN WITNESS THEREOF, Presbyterian Health Plan, Inc. has caused this Group/Subscriber Agreement/Schedule of Benefits Endorsement to be executed by a duly authorized agent.**

PRESBYTERIAN HEALTH PLAN, INC.

_____

Lisa Farrell
Treasurer
Presbyterian Health Plan, Inc.

**PRESBYTERIAN HEALTH PLAN INC.**

**SMART CARE**
**LARGE & SMALL GROUP**
**HMO**

**ENDORSEMENT REGARDING WEB VISITS**

**Effective 05/01/07**

All terms, benefits, exclusions and provisions of the Schedule of Benefits and Group Subscriber Agreement not specifically amended by this Endorsement shall remain in full force and in effect.

**For the Smart Care, under the Schedule of Benefits, the subsection "Physician Services" has added the following:**

| | **COPAYMENT** |
|---|---|
| **Web Visits**<br>***Provided through PHP contracted Web Visits Providers as identified in the Provider Directory.*** | |
| • **Primary Care Physician (PCP)** | **$7 Copayment per visit** |
| • **Specialist** | **$7 Copayment per visit** |

**For the Smart Care, under the Schedule of Benefits, the subsections "Clinical Preventive Services" and "Women's Health Care" have added the following:**

| | **COPAYMENT** |
|---|---|
| **Web Visits**<br>***Provided through PHP contracted Web Visits Providers as identified in the Provider Directory.*** | **$7 Copayment per visit** |

**Throughout the Group Subscriber Agreement and the Schedule of Benefits, the exclusion for "electronic mail (E-mail)" has been removed. "Electronic mail (E-mail)" is a Covered benefit.**

**Section XVII. Glossary of Terms, under the Group Subscriber Agreement;**
**The following definition has been added:**

**WEB VISITS** means an online consultation between a doctor and an established patient about a non-urgent healthcare matter.

**IN WITNESS THEREOF, Presbyterian Health Plan, Inc., has caused this Schedule of Benefits and Group Subscriber Agreement Endorsement to be executed by a duly authorized agent.**

PRESBYTERIAN HEALTH PLAN, INC.

Lisa Farrell
Vice President & Chief Financial Officer
Presbyterian Health Plan, Inc.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**CUSTOM CARE, VALUE CARE, MY CARE ACTIVE/FAMILY, SMART CARE**
**LARGE & SMALL GROUP**
**HMO**

**ENDORSEMENT REGARDING The Removal of the Transplant Lifetime Maximum**

**Effective 01/01/07**

All terms, benefits, exclusions and provisions of the Group Subscriber Agreement and Schedule of Benefits not specifically amended by this Endorsement shall remain in full force and in effect.

**Section IV. Benefits, item Y. (Transplants) of the Group Subscriber Agreement - The following language has been deleted:**

**All transplant benefits, including travel, and Immunosuppressive medications are limited to a Lifetime Maximum Benefit of $500,000.**

**Section VI. Limitations, item C. of the Group Subscriber Agreement - The following language has been deleted:**

**Total lifetime benefits per Member for any and all Organ transplants are limited to $500,000**.

**The following language located in the Schedule of Benefits has been deleted:**

| | | |
|---|---|---|
| **MAXIMUM LIFETIME TRANSPLANT BENEFIT** | $500,000 (including Immunosuppressive drugs) | **Not Covered** |

**Throughout the Schedule of Benefits, any reference to "Subject to Lifetime Transplant Maximum" has been deleted.**

**IN WITNESS THEREOF, Presbyterian Health Plan, Inc. has caused this Group Subscriber Agreement Endorsement to be executed by a duly authorized agent.**

PRESBYTERIAN HEALTH PLAN, INC.

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Lisa Farrell
Vice President & Chief Financial Officer
Presbyterian Health Plan, Inc.

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489
Phone (505) 923-5700
www.phs.org

*Para recibir información en español sobre el contenido de esta planilla, sírvase llamar al Departamento de servicios para los Miembros del Plan al (505) 923-5678, o al 1-800-356-2219.*

January 1, 2007

Dear Presbyterian Health Plan Member:

Thank you for your membership with Presbyterian Health Plan. Presbyterian's purpose is to improve the health of individuals, families and communities, and we always look for ways to better serve our members. As a valued member of our health plan, we are pleased to share some important information with you about an enhancement to your transplant coverage effective January 1, 2007.

The lifetime maximum for transplants has been removed on your policy. This means that transplants will have an unlimited plan lifetime maximum. The enclosed endorsement to your policy indicates the $500,000 transplant lifetime maximum has been removed. The current $10,000 limited travel expense maximum for transplants will remain in effect.

We value your participation as a member of our health plan and encourage you to be an active member of your health care team by being an informed consumer. If you have any questions, please contact a Presbyterian Member Services Representative via e-mail at info@phs.org. You may also call (505) 923-5678 or toll free at 1-800-356-2219. Presbyterian Member Services Representatives are available Monday through Friday from 7 a.m. to 6 p.m. to assist you.

We look forward to serving your healthcare needs.

Sincerely,

Jim Brown
Chief Operations Officer
505-923-5925
Jbrown4@phs.org
*Another member of Presbyterian working to improve your health.*

*Presbyterian serves to improve the Health of individuals, families and communities.*

PRESBYTERIAN

Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489
www.phs.org

October 15, 2008

*Para recibir información en español sobre el contenido de esta planilla, sírvase llamar al Departamento de servicios para los Miembros del Plan al (505) 923-5678 o 1-800-356-2219.*

Dear Member:

Thank you for your membership with Presbyterian Health Plan. Our purpose is to improve the health of individuals, families, and communities, and we always look for ways to better serve our members. As a valued member of our health plan, we would like to provide you with an endorsement to your member materials that outlines your covered benefits.

As of December 15, 2008, there will be two diagnostic tests that will need a "Benefit Certification" or "Pre-authorization." The two tests are the Computerized Axial Tomography (CAT) scan and the Magnetic Resonance Imaging (MRI) test. On the back side of this letter, please find the endorsement with these changes identified. **Keep this letter and endorsement with your current member materials.**

If you have any questions, please contact a Presbyterian Member Services Representative by e-mail at info@phs.org. You may also call (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7 a.m. to 6 p.m.

Sincerely,

Jim Brown
Chief Operations Officer
(505) 923-5678
Jbrown4@phs.org

[MPC090837PHP]

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**PHP Custom/Value Care Plans**
**PHP My Care Plans**
**PHP Smart Care Plans**
**PHP Flex/Choice Care Plans**
**PHP Alliance Group and Individual Plans**
**PHP Minimum Health Care Protection Plan**
**PHP Conversion Plan**

**ENDORSEMENT REGARDING Benefit Certification or Preauthorization Requirement for MRI/CAT Scans**

**Effective 12/15/08**

All terms, benefits, exclusions and provisions of the Group Subscriber Agreement and Schedule of Benefits not specifically amended by this Endorsement shall remain in full force and in effect.

**Section V. (Benefit Certification/Preauthorization), item C. (What Services and Supplies Require Benefit Certification), of the Subscriber Agreement – Computed Axial Tomography (CAT) scans and Magnetic Resonance Imaging (MRI) tests have been added to the list requiring Benefit Certification and will be listed as follows:**

**C. What Services and Supplies Require Benefit Certification or Preauthorization?**

Computed Axial Tomography (CAT) Scans;
Magnetic Resonance Imaging (MRI) tests;

**The following language located in the Schedule of Benefits has been amended to read as follows:**

| **MEDICAL SERVICES – Outpatient** |
|---|
| • **PET[(1)]/CAT[(1)] Scans** |

| |
|---|
| • **Magnetic Resonance Imaging (MRI)[(1)] tests** |

**[(1)] Benefit Certification or Pre-authorization may be required**

**IN WITNESS THEREOF, Presbyterian Health Plan, Inc. has caused this Subscriber Agreement Endorsement to be executed by a duly-authorized agent.**

PRESBYTERIAN HEALTH PLAN, INC.

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Lisa Farrell
Treasurer
Presbyterian Health Plan, Inc.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10047**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

**This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.**

| BENEFIT | COPAYMENT |
|---|---|
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$7 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$17 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$37 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | *15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year*<br>*$0 Copayment* |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *3 x Non-Preferred Copay (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10048**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

**This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.**

| BENEFIT | COPAYMENT |
|---|---|
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$7 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$25 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| Brand (when a generic equivalent is available) | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$45 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item)* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | <br>15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year<br>$0 Copayment |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | 3 x Non-Preferred Copay (90-day supply *up to the maximum dosing recommended by the manufacturer*) |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through a designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10049**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

**This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.**

| BENEFIT | COPAYMENT |
|---|---|
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$10 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$20 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| Brand (when a generic equivalent is available) | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$40 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item)* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | <br>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year<br>$0 Copayment |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | 3 x Non-Preferred Copay (90-day supply *up to the maximum dosing recommended by the manufacturer*) |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through a designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10050**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

**This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.**

| BENEFIT | COPAYMENT |
|---|---|
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$10 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$30 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| Brand (when a generic equivalent is available) | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$50 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item)* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | <br>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year<br>$0 Copayment |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | 3 x Non-Preferred Copay (90-day supply *up to the maximum dosing recommended by the manufacturer*) |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through a designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10051**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

| **This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.** | |
|---|---|
| **BENEFIT** | **COPAYMENT** |
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$10 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$35 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| Brand (when a generic equivalent is available) | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$55 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item)* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | <br>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year<br>$0 Copayment |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | 3 x Non-Preferred Copay (90-day supply *up to the maximum dosing recommended by the manufacturer*) |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through a designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10052**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

**This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.**

| BENEFIT | COPAYMENT |
|---|---|
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$15 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$35 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| Brand (when a generic equivalent is available) | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$55 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item)* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | <br>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year<br>$0 Copayment |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | 3 x Non-Preferred Copay (90-day supply *up to the maximum dosing recommended by the manufacturer*) |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available a through Mail Order. They must be obtained through designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10055**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

| **This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.** | |
|---|---|
| **BENEFIT** | **COPAYMENT** |
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$10 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$25 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$40 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | *15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year*<br>*$0 Copayment* |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *3 x Non-Preferred Copay (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

PRESBYTERIAN
*offered by Presbyterian Health Plan*

**HMO/POS PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**(HHR10103)**

Your employer has elected the following prescription drug benefits

**SCHEDULE OF BENEFITS**

**This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.**

| BENEFIT | COPAYMENT |
|---|---|
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$10 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$20 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| Brand (when a generic equivalent is available) | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$35 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item)* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | <br>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year<br>$0 Copayment |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | 3 x Non-Preferred Copay (90-day supply *up to the maximum dosing recommended by the manufacturer*) |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through a designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489
www.phs.org

September 15, 2009

*Si usted desea recibir información en español sobre el contenido de este documento, sírvase llamar a nuestro Centro de Atención a los Clientes al (505) 923-5678 o al 1-800-356-2219, de lunes a viernes, de las 7 de la mañana a las 6 de la tarde o a la línea telefónica TTY para personas con problemas auditivos al 1-877-298-7407.*

Dear Presbyterian Health Plan Member:

Thank you for your membership with Presbyterian Health Plan. Our purpose is to improve the health of individuals, families and communities, and we always look for ways to better serve our members.

As a valued member of our health plan, we want to keep you informed of changes related to your health benefits. We are writing to you today to share some important news with you about recently enacted legislation in New Mexico, which has provided enhancements to your benefits.

The attached endorsement lists the enhancements and the effective dates to your current benefit plan. Keep this endorsement along with your other member materials in a safe place.

We value your participation as a member of our health plan and encourage you to be an active member of your healthcare team by being an informed consumer. If you have any questions, please contact a Presbyterian Customer Service Center Representative by e-mail at info@phs.org. You may also call (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407.

We look forward to serving your healthcare needs.

Healthy regards,

The Presbyterian Customer Service Center Team
(505) 923-5678 or toll-free at 1-800-356-2219
info@phs.org

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**PHP Custom/Value Care Plans**
**PHP My Care Plans**
**PHP Smart Care Plans**
**PHP Flex/Choice Care Plans**
**PHP Alliance Group Plan**
**PHP Minimum Health Care Protection Plan**

**ENDORSEMENT REGARDING –Children's Health Insurance Program Reauthorization Act (CHIPRA) Special Enrollment**

**Effective April 1, 2009**

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* and/or *Schedule of Benefits* not specifically amended by this *Endorsement* shall remain in full force and in effect.

**Children's Health Insurance Program Reauthorization Act (CHIPRA) Enrollment**
The following changes were made to your *Group Subscriber Agreement*:

In the *Eligibility, Enrollment and Effective Dates* Section, under "Special Enrollment" the following has been added:

3. CHIPRA (in accordance with provisions as currently may be defined under federal law)

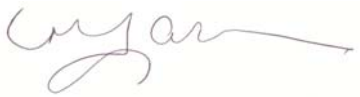
   a. An employee, who chose not to enroll in PHP for self and/or dependent(s) during a previous enrollment period because they were covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, may request coverage for self 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.

   b. An employee, who chose not to enroll in PHP 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.

   c. 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 then the first day of the month following receipt of your enrollment request.

**IN WITNESS THEREOF, Presbyterian Health Plan, has caused this *Group Subscriber Agreement* and/or *Schedule of Benefits* Endorsement to be executed by a duly-authorized agent.**

**PRESBYTERIAN HEALTH PLAN**



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Lisa Farrell
Treasurer
Presbyterian Health Plan

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**PHP Conversion Plan**
**PHP Custom/Value Care Plans**
**PHP My Care Plans**
**PHP Smart Care Plans**
**PHP Flex/Choice Care Plans**
**PHP Alliance Group and Individual Plans**

**ENDORSEMENT REGARDING – Cancer Clinical Trials Benefit Enhancements**

**Effective July 1, 2009**

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* and/or *Schedule of Benefits* not specifically amended by this *Endorsement* shall remain in full force and in effect.

Coverage for Cancer Clinical Trials will follow the guidance set forth in Senate Bill 24. As such, the following changes are made to your Group Subscriber Agreement:

A. Where "Cancer Clinical Trials" is listed in the Benefits section, the Limitations and Exclusions section, and the Glossary delete the words "phase I, II, III or IV."

B. Also, in the Benefits section and Glossary, the definition of Cancer Clinical Trials, "routine costs" now reads as follows:

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

a. The Cancer Clinical Trial is undertaken for the purposes of the **prevention of or** the prevention of reoccurrence, early detection, or treatment of cancer for which no equally or more effective standard cancer treatment exists.

b. The Cancer Clinical Trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.

c. The Cancer Clinical Trial is being provided **in New Mexico** as part of a scientific study of a new therapy or intervention.

d. There is not a non-Investigational treatment equivalent to the Cancer Clinical Trial.

e. There is a reasonable expectation shown in clinical or pre-clinical data that the Cancer Clinical Trial will be at least as efficacious as any non-Investigational alternative.

**f. There is a reasonable expectation based on clinical data that the medical treatment provided in the Cancer Clinical Trial will be at least as effective as any other medical treatment.**

**g. Pursuant to the patient informed consent, Presbyterian is not liable for damages associated with the treatment provided during any phase of a Cancer Clinical Trail.**

**IN WITNESS THEREOF, Presbyterian Health Plan, has caused this *Group Subscriber Agreement* and/or *Schedule of Benefits* Endorsement to be executed by a duly-authorized agent.**

PRESBYTERIAN HEALTH PLAN

_____

Lisa Farrell
Treasurer
Presbyterian Health Plan

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**Commercial Small/Large Group (HMO)**

**ENDORSEMENT REGARDING –** Autism Spectrum Disorder Diagnosis and Treatment Benefit

**Effective July 1, 2009**

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* and/or *Schedule of Benefits* not specifically amended by this *Endorsement* shall remain in full force and in effect.

Coverage for Autism Spectrum Disorder Diagnosis and Treatment in accordance with Senate Bill 39. As such, the following changes are made to the respective *Schedules of Benefits* and *Group Subscriber Agreements*:

A. Under the Covered Benefits section, the following is added:

Autism Spectrum Disorder

The diagnosis and treatment for Autism Spectrum Disorder is covered for children, from birth to age nineteen (19) (or up to age twenty-two (22) if enrolled in high school) in accordance with state mandates (Senate Bill 39) as follows:

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

These services are only covered when a treatment plan is provided to Presbyterian Health Plan's Health Services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with Senate Bill 39.

Autism Spectrum Disorder Services must be provided by Participating Providers/Practitioners who are certified, registered or licensed to provide these services. Applied Behavioral Analysis (ABA) and other Autism Spectrum Disorder services may require Benefit Certification prior to being provided. If Benefit Certification is not obtained when required, the claim may be denied.

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

B. Under Benefits, Rehabilitation and Therapy, Long Term Therapy, delete the word "autism" in the second sentence.

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

**IN WITNESS THEREOF, Presbyterian Health Plan, has caused this *Group Subscriber Agreement* and/or *Schedule of Benefits* Endorsement to be executed by a duly-authorized agent.**

PRESBYTERIAN HEALTH PLAN

_____

Lisa Farrell
Treasurer
Presbyterian Health Plan

Applies to Citigroup only.

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

# Citigroup

## Smart Care Customized Large Group Plan (HHH10117)

## ENDORSEMENT REGARDING – Annual Calendar Year Deductible and Annual Out-of-Pocket Maximum

**January 1, 2010**

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* not specifically amended by this *Endorsement* shall remain in full force and in effect.

Requirements for meeting the Calendar Year Deductible and Out-of-Pocket Maximums have been amended. As such, the following changes are made to the respective *Group Subscriber Agreements*:

Under the Section labeled General Information, Item N. the following **bolded** language has been amended and will now read as follows:

N. Annual Calendar Year Deductible and Out-of Pocket Maximum

**Annual Calendar Year Deductible**

For family coverage, with three or more enrolled Members, **no one member must meet the individual deductible but rather, the Annual Calendar Year Deductible requirement is fulfilled when expenses from family members are combined to meet the family Deductible. No one person may apply more than the individual Deductible towards the family Deductible amount.**

**Annual Calendar Year Out-of Pocket Maximum**

For family coverage, with three or more enrolled Members, **the Annual Out-of-Pocket Maximum is fulfilled when one or a combination of each family member's Out-of Pocket Maximums is met during the Calendar Year. No one person may apply more than the individual Out-of-Pocket Maximum towards the family Out-of-Maximum amount.**

**IN WITNESS THEREOF, Presbyterian Health Plan, has caused this *Group Subscriber Agreement* Endorsement to be executed by a duly-authorized agent.**

PRESBYTERIAN HEALTH PLAN

_____

Lisa Farrell
Treasurer
Presbyterian Health Plan

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489
www.phs.org

December 15, 2009

*Si usted desea recibir información en español sobre el contenido de este documento, sírvase llamar a nuestro Centro de Atención a los Clientes al (505) 923-5678 o al 1-800-356-2219, de lunes a viernes, de las 7 de la mañana a las 6 de la tarde o a la línea telefónica TTY para personas con problemas auditivos al 1-877-298-7407.*

Dear Presbyterian Health Plan Member:

Thank you for your membership with Presbyterian Health Plan. Our purpose is to improve the health of individuals, families and communities, and we always look for ways to better serve our members.

As a valued member of our health plan, we want to keep you informed of changes related to your health benefits. We are writing to you today to share some important changes within your Group Subscriber Agreement.

The attached endorsement lists the changes and the effective date to your current benefit plan. Keep this endorsement along with your other member materials in a safe place.

We value your participation as a member of our health plan and encourage you to be an active member of your healthcare team by being an informed consumer. If you have any questions, please contact a Presbyterian Customer Service Center Representative by e-mail at info@phs.org. You may also call (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407.

We look forward to serving your healthcare needs.

Healthy regards,

The Presbyterian Customer Service Center Team
(505) 923-5678 or toll-free at 1-800-356-2219
info@phs.org

[MPC100928CL]

PRESBYTERIAN

*Offered by Presbyterian Health Plan*

**Alliance Group Plan**
**Choice/Flex Care Plans**
**Custom/Value Care Plans**
**My Care Plans**
**Smart Care Plans**

**ENDORSEMENT REGARDING:**
**Changes to the EFFECT OF OTHER COVERAGE Section**

**Effective January 1, 2010**

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* not specifically amended by this Endorsement shall remain in full force and in effect.

**In Section X. (Effect of Other Coverage), the "Explanation Box" has been amended and reads as follows:**

**EFFECT OF OTHER COVERAGE**

***Some Members may have medical Coverage through other health benefit plans. This Section explains how Presbyterian Health Plan (PHP) coordinates these benefits along with your PHP Coverage.***

**Item A. (Coordination of Benefits), 2. g. has been added:**

g. If a Member is Covered under a motor vehicle or homeowners insurance policy which provides benefits for medical expenses resulting from a motor vehicle accident or accident in the Member's own home, the Member shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are Covered by their motor vehicle or homeowners' insurance policy. If such benefits have been provided by PHP, PHP shall have the right to recover any benefits provided from the Member or from the motor vehicle or homeowners' insurance to the extent they are available under the motor vehicle or homeowners' insurance policy.

**Item D. Med-Pay (Motor Vehicle, Homeowners Policies) has been deleted.**

**IN WITNESS THEREOF, Presbyterian Health Plan has caused this *Group Subscriber Agreement* Endorsement to be executed by a duly-authorized agent.**

PRESBYTERIAN HEALTH PLAN

_____
Lisa Farrell
Treasurer
Presbyterian Health Plan

**PRESBYTERIAN HEALTH PLAN (PHP)**
**HMO PLAN**
**4-TIER PRESCRIPTION DRUG RIDER**
**HHR10049**

Your employer has elected the following prescription drug benefits.

**SCHEDULE OF BENEFITS**

| **This plan is considered Creditable per Medicare Part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.** | |
|---|---|
| **BENEFIT** | **COPAYMENT** |
| **PRESCRIPTION DRUGS RETAIL** | |
| *Generic (Preferred) - Tier 1* | *$10 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Brand (Preferred) - Tier 2* | *$20 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| Brand (when a generic equivalent is available) | *Generic Copay plus the difference in the cost of the brand and generic (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | *$40 Copay (30-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Pre-packaged items* | *One applicable Copay (generic, brand, non-preferred) per manufacturer pre-packaged item)* |
| *Specialty Pharmaceuticals - Tier 4*<br>*Oral or inhalation forms/Self Administered*<br>*Intravenous (IV)* | <br>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year<br>$0 Copayment |
| **PRESCRIPTION DRUGS MAIL ORDER** | |
| *Generic (Preferred) - Tier 1* | *2 x generic Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (Preferred) - Tier 2* | *2.5 x brand Copay (90-day supply* up to the maximum dosing recommended by the manufacturer*)* |
| *Brand (when a generic equivalent is available)* | *Generic Copay plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)* |
| *Non-Preferred - Tier 3* | 3 x Non-Preferred Copay (90-day supply *up to the maximum dosing recommended by the manufacturer*) |
| *Specialty Pharmaceuticals - Tier 4* | *Specialty pharmaceuticals are not available through Mail Order. They must be obtained through a designated specialty pharmacy vendor and may be subject to Benefit Certification.* |

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

# Your VSP Vision Benefits

Welcome to VSP® Vision Care. We'll help keep you and your eyes healthy through personalized care from a doctor you can trust.

Your eyes say a lot about you and can even tell your VSP doctor about you. During your WellVision® Exam, your VSP doctor will look for vision problems and signs of health conditions too.

## Getting started is a breeze.

- **Find the right VSP doctor for you.** You'll find plenty to choose from at **vsp.com** or by calling **800.877.7195**.
- **Already have a VSP doctor?** Make an appointment today and tell them you're a VSP member.
- **Check out your coverage and savings.** Visit **vsp.com** to see your benefits anytime and check out how much you saved with VSP after your appointment.

That's it! We'll handle the rest – no ID card necessary or claim forms to complete.

Visit the Eyecare Discovery Center at vsp.com for eye health articles, videos, and interactive games.

**Keep your eyes healthy and your vision clear. Make your appointment today!**

Presbyterian Health Plan and VSP provide you an affordable eyecare plan.

## Your Coverage from a VSP Doctor

**WellVision Exam®** focuses on your eye health and overall wellness

- $0 copay ..... ***every 24 months***

**Prescription Glasses Discounts**

**Lenses**

- *20% discount when a complete pair of glasses is purchased*

**Frames**

- *20% discount when a complete pair of glasses is purchased*

**Contacts**

*15% discount off the contact lens fitting and evaluation exam. This additional exam ensures proper fit of your contacts.*

## Extra Discounts and Savings

**Glasses and Sunglasses**

- *20% off lens options like progressives and scratch-resistant and anti-reflective coatings*
- *20% off additional glasses and sunglasses, including lens options**

**Contacts***

- *15% off cost of contact lens exam (fitting and evaluation)*

**Laser Vision Correction**

- *Average 15% off the regular price or 5% off the promotional price from contracted facilities*

** Available from any VSP doctor within 12 months of your last eye exam*

*VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.*

Contact VSP | **vsp.com** **800.877.7195**

VSP® Vision care for life

5/08 CAT#01946 JOB#203CM