Presbyterian
Insurance Company, Inc.

SUBSCRIBER AGREEMENT

AND GUIDE TO YOUR HIGH DEDUCTIBLE HEALTH PLAN (HDHP) FOR A PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

SAVVY100
with Comprehensive Dental
INDIVIDUAL PLAN
HIGH DEDUCTIBLE HEALTH PLAN
PPO BENEFIT PLANS

Underwritten by
Presbyterian Insurance Company, Inc.,
Delta Dental Plan of New Mexico, Inc.

IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service Center:

Address:
Presbyterian Insurance Company, Inc.
P.O. Box 26267
Albuquerque, New Mexico 87125-6267
Attention: Customer Service Center

Phone:
(505) 923-6980 or toll-free
at **1-800-923-6980**
TTY/TDD for the hearing impaired: (505) 923-5699
Or toll-free (877) 298-7407

Benefit Certification:

Address:
Presbyterian Insurance Company, Inc.
P.O. Box 26267
Albuquerque, New Mexico 87125-6267
Attention: Health Services Department

Phone:
(505) 923-5757 or toll-free
at **1-888-923-5757**

Claims:

Address:
Presbyterian Insurance Company, Inc.
P.O. Box 26267
Albuquerque, New Mexico 87125-6267
Attention: Claims Department

Phone:
(505) 923-6980 or toll-free
at **1-800-923-6980**

Appeals and Grievances:

Address:
Presbyterian Insurance Company, Inc.
P.O. Box 26267
Albuquerque, New Mexico 87125-6267
Attention: Appeals and Grievances Department

Phone:
(505) 923-5644 or toll-free
at **1-800-356-2219**

Website:

www.phs.org

Welcome to Presbyterian Insurance Company, Inc.

Welcome and thank you for joining Presbyterian Insurance Company, Inc. (PIC). PIC is operated as a division of Presbyterian Healthcare Services, a locally owned New Mexico based healthcare system.

PIC provides you with access to a comprehensive provider network, benefits for Out-of-network Services, a quality medical management program, commitment to Member service, and cost-effective, healthcare services.

This booklet is your *Subscriber Agreement*. Your *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 PIC. 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 PIC
- What types of services require Benefit Certification
- Limitations and exclusions of Covered Benefits for your plan
- Glossary of some of the terms used in this *Subscriber Agreement*

As always, if you have any questions about your benefit plan you may call our Presbyterian Customer Service Center at **(505) 923-6980** or toll-free at **1-800-923-6980.** TTY users may call **1-877-298-7407** or visit our website at www.phs.org. These numbers are also listed on the back of your PIC ID Card. Our Customer Service Center Representatives are available to Monday through Friday from 7:00 a.m. to 6:00 p.m. to assist you.

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

You may also visit our website for useful health information and services at www.phs.org. PIC is a part of the Presbyterian Healthcare Services family of companies.

Presbyterian exists to improve the health of the patients, members, and communities we serve.

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Some of the terms used throughout this Agreement will be capitalized. These terms are defined in the Glossary of Terms section.

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I. INTRODUCTION

Some of the terms used throughout this document will be capitalized. These terms are defined in the Glossary of Terms section. 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 Insurance Company, Inc., ("PIC"). We are pleased to welcome you and look forward to serving your healthcare needs. This booklet is your *Subscriber Agreement* ("Agreement") and describes the medical, Hospital, and related healthcare benefits that you and your eligible Dependents (if any) may receive as Enrollees.

B. How the Plan Works

This plan is a fully Qualified High Deductible Health Plan (HDHP) which means that you must meet an individual or family Deductible before any benefits (including pharmacy benefits) are paid out by PIC. Once the Deductible is met, you will be required to pay a Co-insurance (in most cases) or a portion of the cost of the Covered services that are provided. This is explained in greater detail in the General Information section.

Some preventive benefits are not subject to the Deductible. This means you can access this benefit and the plan will pay even if you have not met the individual or family Deductible. Please see the "Clinical Preventive Services" benefit on your *Schedule of Benefits* for further information. Prescription Drugs are not part of the Clinical Preventive Services benefit and thus, are subject to the Deductible and Co-insurance listed in the *Schedule of Benefits*.

This Plan is qualified for use in conjunction with a Health Savings Account (HSA). Please see the "HSA Note(s)" posted throughout this document. Please remember, though, that this booklet describes only the medical/surgical benefits available to you. HSAs are not administered by PIC and are regulated by the United States Department of the Treasury (United States Treasury). For more information, please see the United States Treasury's website at: http://www.ustreas.gov/offices/public-affairs/hsa.

This plan is a Preferred Provider Organization or **"**PPO." People who receive healthcare benefits through a PPO are sometimes called "Enrollees" or "Subscribers." **In order to be eligible to enroll and continue to participate in this plan you must physically live in the Service Area**, unless you are a Dependent and meet all of the terms and conditions for such Coverage in the Eligibility, Enrollment and Effective Dates section. PIC's PPO Service Area is described in Exhibit A of this Agreement. PIC 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, PIC refers to its Enrollees and Subscribers as Members of our health plan. If you, as a Dependent live outside the Service Area, you can receive benefits from a Participating Provider/Practitioner at the In-network benefit level by traveling into the Service Area.

This PPO plan allows you to choose, at the time you receive services, the level of benefits that will apply. You receive the highest benefit level with the lowest cost to you when you obtain services from a Participating Provider/Practitioner. The PIC Provider Directory lists the Participating Providers/Practitioners.

As a Member of PIC, 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 PIC before providing these services to you.

You are responsible for ensuring that Non-participating Providers/Practitioners have obtained Benefit Certification when Benefit Certification is required. Refer to the Benefit Certification section.

C. In-network Benefits

As a Member of our PPO, you will generally not have claims to file or papers to fill out in order to be reimbursed for medical services obtained from Participating Providers/Practitioners for payment to be made. Your Participating Provider/Practitioner will bill us directly. **Most doctor visits and Hospital admissions do, however, require Co-insurance and/or Copayments at the time of service.** Co-insurance is the percentage of Covered charges that you must pay for Covered services after the Deductible has been met. The amount of your Co-insurance or Copayment for each service can be found in your *Schedule of Benefits*. The Co-insurance will be applied to the Total Allowable Charges or billed charges, whichever is less, for the particular procedure allowed by PIC. Participating Providers/Practitioners are not required by PIC to comply with any specified numbers, targeted averages, or maximum duration of patient visits.

D. Out-of-network Benefits

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

If you receive care from Providers/Practitioners who are Non-Participating, payments by PIC for Covered services will be limited to Reasonable and Customary Charges. **You will be responsible for any balance due above the Reasonable and Customary Charges, in addition to any applicable Deductibles or Co-insurance.** Reasonable and Customary Charges are defined in the Glossary of Terms section of this Agreement. If a Participating Provider/Practitioner recommends or refers you to a Non-participating Provider/Practitioner services from that Non-participating Provider/Practitioner are subject to the Out-of-network benefits, as shown in the *Schedule of Benefits***.**

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 PIC.

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

Presbyterian Insurance Company, Inc.
P.O. Box 26267
Albuquerque, NM 87125-6267

Some services are not Covered when received from a Non-participating Provider/Practitioner. Please refer to your *Schedule of Benefits* and throughout this Agreement for a complete listing of Covered services.

For services requiring Benefit Certification **you are responsible for ensuring that proper Benefit Certification has been obtained before receiving services from Non-participating Providers/Practitioners.**

E. Benefit Certification

Certain procedures or services, as identified in the Benefit Certification section of this Agreement require Benefit Certification. Benefit Certifications are granted for specific providers and specific services as requested. Services rendered beyond the scope of the Benefit Certification are not Covered, providers and members must coordinate accordingly. For more information on Benefit Certifications, please see the Benefit Certifications section of this Agreement. The responsibility for obtaining this Benefit Certification is as follows:

1. In-network - When accessing In-network Benefits, the Participating Provider/Practitioner is responsible for obtaining Benefit Certification from PIC or PIC's designee before providing these services to you.

2. Out-of-network **-** When accessing Out-of-network Benefits, you are responsible for obtaining Benefit Certification from PIC or PIC's designee before obtaining the Out-of-network Services. If Benefit Certification is not obtained when required, then the services will not be Covered by PIC and **payment will be your responsibility**.

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

F. Important Instructions

This Agreement describes your benefits, rights and responsibilities as a Member of PIC. It also gives details on the limits 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 PIC Customer Service Center at **(505) 923-6980** or toll-free at **1-800-923-6980** Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407** or visit our website at www.phs.org.

Help is available if you need assistance with completing PIC forms, have special needs, or you need assistance in protecting your rights as a PIC Member, call a PIC Consumer Assistance Coordinator at **(505) 923-5644** or toll-free at **1-800-923-6980**. TTY users may call **1-877-298-7407** or visit our website at www.phs.org.

PIC may be contacted in writing at the following address:

Presbyterian Insurance Company, Inc.
P.O. Box 26267
Albuquerque, New Mexico 87125-6267
Attention: Customer Service Center

II. MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of Presbyterian Insurance Company, Inc., 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 insurer. 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 PIC Members have a right to:

1. receive information about the organization, its services, its Practitioners and Providers, and members' 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 PIC and its healthcare Providers/Practitioners as required by law.
4. participate with treating Providers/Practitioners in making decisions about their health care.
5. candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit Coverage.
6. voice Complaints or Appeals about PIC or the care it provides to PIC 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 policies.
8. request and obtain information concerning PIC's policies and procedures regarding products, services, Participating Providers/Practitioners, Appeals procedures and other information about PIC and the benefits provided.
9. request and obtain information about any financial arrangements between PIC and its Participating Providers/Practitioners which might restrict treatment options or limit services offered to Members.
10. pay all required, predetermined Copayments at the time services are rendered when 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 receive non-Covered services or receive services without required Benefit Certification.

11. 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 Certifications, when needed.

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

13. be notified promptly of termination, decreases or changes in benefits or services.

14. 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.

15. receive information from their treating Provider/Practitioner, in terms 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 PIC's position on treatment options.

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

17. have all explanations to the next of kin, guardian, agent or surrogate recorded in the Member's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Member.

18. have access to services, when Medically Necessary, as determined by their treating Provider/Practitioner, in consultation with PIC, 24 hours per day, 7 days a week for Urgent or Emergency Health Services, and for other health services as defined by this Agreement.

19. have access to translator services for Members who do not speak English as their first language, and translation services for hearing-impaired Members for communication with PIC.

20. receive a complete explanation of why services or benefits are denied, an opportunity to Appeal the decision to PIC's internal review, and the right to request the superintendent's assistance. See the Complaints, Grievances and Appeals section.

21. receive a Certificate of Creditable Coverage when a Member's enrollment in PIC terminates.

B. Member Responsibilities

All PIC Members must:

1. provide as much as possible, information that PIC 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 instructions for care that he/she has agreed upon with his/her treating Provider/Practitioner. A Member may, for personal reasons, refuse to accept treatment recommended by Providers/Practitioners. A Provider/ Practitioner may regard such refusal as incompatible with the continuance of the Provider/Practitioner-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 *Subscriber Agreement* and if there are questions contact our Customer Service Center at **(505) 923-6980** or toll-free at **1-800-923-6980,** Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407** or our website at www.phs.org for clarification of benefits, limitations, and exclusions outlined in this *Subscriber Agreement*.

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

6. notify PIC within 31 days of any change of name, address, marital status, eligible Dependents or newborns.

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

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

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

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

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 the Termination section item F.

12. promise that all information given to PIC 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 PIC, as described in the General Information section of this Agreement.

14. be responsible for obtaining Benefit Certification as described in the Benefit Certification section of this Agreement.

15. be responsible for any charges over Reasonable and Customary.

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 Provider/Practitioner, in consultation with Presbyterian Insurance Company, Inc. (PIC), 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 PIC 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 even if it is not specifically listed as an exclusion.

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

   PIC 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 Deductible, Copayment and/or Co-insurance amount, if any, directly to the Provider/Practitioner of healthcare services at the time services are rendered.

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

You generally won't have 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 PIC directly. Most medical services do, however, require Copayments, Co-insurance or Deductible at the time of service. The amount of your responsibility 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 PIC.

C. Court Ordered Coverage for Dependent Children

When a Subscriber who is eligible for family Coverage has been ordered by a court or qualified administrative order to provide health insurance Coverage for a Dependent child who is eligible for the plan, Coverage will be provided and regular in and Out-of-network benefits will be administered regardless of if the Dependent lives in or out of the PIC Service Area.

D. Non-Custodial Parents

When a child has Coverage through a non-custodial parent, PIC 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.

E. Annual Calendar Year Deductible and Out-of-Pocket Maximum

1. Annual Calendar Year Deductible

All services are subject to an annual Calendar Year Deductible. The amount of your annual Deductible can be found in your *Schedule of Benefits*. **This Deductible must be paid for by a Member each Calendar Year toward Covered services before health benefits for that Member will be paid by PIC.**

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

If family Coverage is elected, the **entire** family Deductible must be met before benefits will be paid. There is no individual Deductible that a Member must meet when family Coverage is elected. One family Member may satisfy the **entire amount** for the whole family**.**

Some plans include a preventive benefit that is not subject to the Deductible. This means you can access this benefit and the plan will pay (up to a certain amount) even if you have not met the individual or family Deductible. Please see the "Preventive Services" benefit on your *Schedule of Benefits* for further information.

Covered charges for Participating Provider/Practitioner (In-network) services do not apply to the Non-participating Provider/Practitioner (Out-of-network) Deductible, nor vice versa.

2. **Changes to Deductible**

a. Upgrades to a lower Deductible plan may be requested once each 12-month period and will be subject to underwriting approval. If approved, the change will become effective on the first of the month following 60 days from the date of the approval.

b. Downgrades to a higher Deductible plan will be allowed in cases of a Prepayment increase as identified in the Premium Payment section item B. Request for Deductible plan change in such cases must be received by PIC within 31 days from the date of the Prepayment increase and the change in plan will become effective the first of the month following receipt of the request.

3. **Annual Out-of-Pocket Maximum**

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

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

For family Coverage, the **entire** family Annual Out-of-Pocket Maximum must be met before benefits will be paid at 100%. There is no individual Out-of-Pocket Maximum that a Member must meet when family Coverage is elected. One family Member may satisfy the **entire amount** for the whole family**.**

The Annual Out-of-Pocket Maximum includes Deductible, Co-insurance, and Copayments but does not include penalty amounts and non-Covered charges.

Covered charges for Participating Provider/Practitioner (In-network) services do not apply to the Non-participating Provider/Practitioner (Out-of-network) Out-of-Pocket Maximum, nor vice versa.

F. Transition of Care

If you are in an ongoing course of treatment with a Participating Provider/Practitioner and that Participating Provider/Practitioner becomes a Non-participating Provider/Practitioner, you may elect to continue to receive care from this Provider/Practitioner, however PIC will only pay for such services in accordance with applicable Out-of-network benefits, if any, and then up to Reasonable and Customary charges.

G. Pre-existing Conditions Limitation

A Pre-existing Condition limitation will apply to any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to the Member's enrollment under this plan. All Members (excluding Dependents under age 19) are subject to a six-month Pre-existing Condition limitation.

No benefits will be payable for services related to the Pre-existing Condition during the Pre-existing Condition limitation time period. After the applicable Pre-existing Condition limitation time period is satisfied, regular plan Coverage provisions apply without any Pre-existing Condition limitation.

The Pre-existing Condition limitation time period may be offset by coverage the Member had under another plan. To receive credit for coverage under another plan, you will need to provide PIC with a Certificate of Creditable Coverage or similar acceptable evidence.

Any period of creditable Coverage shall be applied to reduce the Pre-existing Condition limitation time period, except that no creditable coverage shall be considered if, after such creditable coverage, there occurs a continuous 95 day period during all of which the individual was not covered under Creditable Coverage.

The Pre-existing Condition limitation does not apply to children under age 19. The Pre-existing Condition limitation does not apply to conditions or a newborn child or adopted child if enrolled in the plan within 31 days of birth or date of placement. **Pregnancy and pregnancy-related diagnoses are not Covered.**

H. Utilization Management Procedures

PIC's Care Coordination 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. PIC is committed to the personal service that care coordination 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.

I. Health Management Programs

PIC'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 our Customer Service Center at **(505) 923-6980** or toll-free **1-800-923-6980**, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407**, or visit our website at www.phs.org.

J. 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 directions help healthcare workers care for people.

K. Technology Assessment Committee

PIC continuously evaluates evolving medical technologies, which include medical procedures, drugs and devices. Practitioners from the PPO 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 or 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.

L. Fraud

Fraud increases the cost of health care for everyone. PIC 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 Provider/Practitioner, pharmacy, Hospital or other Provider/Practitioner has done any of the following listed below, please call the Provider/Practitioner and ask for an explanation. There may be an error:

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.)

If you are unable to resolve the issue, or if you suspect any other suspicious activity, please contact PIC 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. PIC 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, PIC can focus on improving the health of individuals, families and communities.

M. Federal and State Health Care Reform

Upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects PIC's obligations under this *Subscriber Agreement*, this *Subscriber Agreement* will be deemed automatically amended such that PIC shall remain in compliance with the obligations imposed by such law, rule or regulation.

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 THE EXCLUSIONS SECTION,**
2. **THE BENEFIT CERTIFICATION REQUIREMENTS OF THE BENEFIT CERTIFICATION SECTION, AND**
3. **THE LIMITATIONS IDENTIFIED IN THE LIMITATIONS SECTION.**

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

A. Accidental Injury/Urgent Care/ Emergency Health/Observation and 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.

   Presbyterian Insurance Company, Inc. (PIC) will reimburse for all services rendered that satisfy this definition, unless otherwise limited or excluded by this Agreement.

   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, 7 days per week, when those services are needed immediately to prevent jeopardy to a Member's health. If Emergency Health Services are administered by either a Participating or Non-participating Provider, benefits for the initial treatment are paid at the In-network benefit level. Non-participating Providers/Practitioners will be reimbursed by PIC up to Reasonable and Customary Charges. You will be responsible for any charges above Reasonable and Customary.

      If the Member is hospitalized within 48 hours of Emergency Health Services, the entire hospitalization will be considered part of the initial treatment. Once the Member is discharged, follow-up care received through a Non-participating Provider/Practitioner will be paid at the Out-of-network benefit level.

b. A Member who, as a result of Emergency Health Services, is admitted to a Non-participating Hospital may choose to be transferred to a Hospital participating in the PIC Provider/Practitioner network. The Member must be stable and can be safely transferred. Refer to Ambulance Services in the *Schedule of Benefits* for the required Co-insurance for inter-facility transportation costs. If the Member chooses to remain at an Out-of-network Hospital, Out-of-network benefits may apply.

c. PIC 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/prudent layperson, 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/prudent layperson" as described in item c. above, PIC 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 PIC's established procedures for obtaining Emergency Health Services.

e. The term "reasonable/prudent layperson" is explained in more detail in the Glossary of Terms section of this Agreement.

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

g. the Member may seek Emergency Health Services from the nearest appropriate facility where Emergency Health Services can be rendered. These services will be Covered as In-network Services. Non-emergent follow-up care outside of PIC's Service Area is Covered as Out-of-network Services.

   All Emergency Health Services, Urgent Care, and trauma care services, whether provided within or outside of PIC's Service Area are subject to the limitations listed in the Limitations section and the exclusions listed in the Exclusions Section of this Agreement.

h. **Use of an emergency facility for non-emergent services is not Covered.**

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, it is on the Providers/Practitioners written order. To transition from observation to an Inpatient admission, level of care criteria used by PIC must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient stays. Medical criteria will also be considered. Observation for greater than 24 hours will require Benefit Certification.

B. Ambulance Services

The following types of Ambulance Services are Covered: (1) Emergency Ambulance Services, and (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/prudent 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. For transportation 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, which is equipped and staffed with life-sustaining equipment and personnel.

   b. PIC 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.

   c. **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.

   d. In determining whether the Member "acted in good faith" as a "reasonable/prudent layperson" when obtaining emergency Ambulance Services, PIC 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 reasonable/prudent 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 Provider/Practitioner or by PIC. Any such advice will result in reimbursement for Medically Necessary services rendered, unless otherwise limited or excluded under this Agreement.

(5) 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.

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 Provider/Practitioner.

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

a. Air Ambulance Service when Medically Necessary. However, PIC 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. Neonatal Ambulance Services**,** including ground or air ambulance transportation to the nearest Tertiary Care Facility when necessary to protect the life of a newborn.

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 Provider/Practitioner; and

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

C. 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 (NMSA §59A-22-49) 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 Insurance Company, Inc.'s Health Services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with NMSA §59A-22-49.

Autism Spectrum Disorder Services must be provided by Providers/Practitioners who are certified, registered or licensed to provide these services. Applied Behavioral Analysis (ABA) and other Autism Spectrum Disorder services will 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.

D. Cancer Clinical Trials

Routine patient care costs that are incurred as a result of participation in a 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 (FDA), 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 Cancer Clinical Trial **only 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 no 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 Trial.

3. The Cancer Clinical Trial 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, PIC will cover services of a Non-participating Provider/Practitioner only if the Provider/Practitioner agrees to accept PIC's normal reimbursement for similar services and services are provided in New Mexico.

5. Any care related to the Cancer Clinical Trial that is Investigational requires Benefit Certification by PIC. Those medical services that are not Investigational such as lab and x-ray services would require Benefit Certification as identified in the Benefit Certification section of this Agreement.

6. **Exclusions**

   In addition to the exclusions listed in the Exclusions section 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 Cancer Clinical Trial that are 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 PIC 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. Costs 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. Costs of tests that are necessary for the research of the Cancer Clinical Trial.

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

E. Clinical Preventive Services

Coverage is provided for the following preventive services 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 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 is still attending high school).**

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. **Immunizations for the purpose of foreign travel are not Covered**.

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.

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 Provider/Practitioner 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.

11. HPV Vaccine Coverage the Human Papillomavirus, as approved by the Food and Drug Administration *in accordance with federal and state requirements and the guidelines established by* The Advisory Committee on Immunization Practices (ACIP), mammography Coverage as described in the Benefit Section of this Agreement.

In accordance with the Patient Protection and Affordable Act (PPACA), Clinical Preventive Services requires the following provisions:

1. Evidence-based items or services that have in effect a ration of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisor Committee on Immunizations Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved.
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

The complete list of recommendations and guidelines that are required to be Covered under these interim final regulations can be found at http://www.healthcare.gov/center/regulations/prevention/html.

F. Complementary Therapies

The only alternative/complementary therapies that are Covered are those that are identified in this Agreement and only when received by a Participating Provider/Practitioner.

Acupuncture services received from Non-participating Providers/ Practitioners are **NOT COVERED**

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 must be part of a coordinated plan of care approved by the Member's Provider/Practitioner.

c. **Acupuncture services are limited to a Calendar Year maximum. Refer to your *Schedule of Benefits* for this maximum.**

d. **Acupuncture services received from Non-participating Providers are not Covered**.

2. **Chiropractic Services (Limited)**

Chiropractic services received from Non-participating Providers/ Practitioners are **NOT COVERED**

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

a. **The Provider/Practitioner must determine** 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 PIC 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 PIC 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 PIC 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. **Chiropractic services are limited to a Calendar Year maximum. Refer to your *Schedule of Benefits* for this maximum.**

i. **Chiropractic services received from Non-participating Providers/Practitioners are not Covered.**

3. **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 the Benefits section item V. (Rehabilitation and Therapy).

G. Dental Services (Limited)

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

1. Accidental Injury to sound natural teeth, jawbones or surrounding tissue. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury.**
2. The correction of a non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
3. The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
4. **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.
5. Oral surgery Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.

6. Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.

7. **Dental implants are not Covered.**

8. **Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)**

   The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) are subject to the same conditions, limitations, and 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**.

H. 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). PIC will guarantee Coverage for the equipment appliances, Prescription Drug, insulin or supplies that meet Food and Drug Administration (FDA) 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 Provider/Practitioner 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 certified, registered or licensed healthcare professionals with recent education in diabetes management.

3. Diabetes Supplies and Services**.** When prescribed by the Member's Provider/Practitioner the following equipment, supplies, appliances, and services are Covered for Members with diabetes.

   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 Orthotic s, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment, when Certified by PIC.

c. Glucagon emergency kits.

The following items (d. through l.) require use of PIC approved brands. For further information please contact our Customer Service Center at **(505) 923-6980** or toll-free at **1-800-923-6980**, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407** or visit our website at www.phs.org for further information.

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

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

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 PIC.

I. 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 the Limitations section, the exclusions listed in the Exclusions section and the Benefit Certification requirements listed in the Benefit Certification section of this Agreement**. All Diagnostic **Services must be provided under the direction of the Member's Provider/Practitioner**. 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. Computed Axial Tomography (CAT) 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. bone density studies.

J. 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.

1. **Durable Medical Equipment**

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 PIC, the purchase of Durable Medical Equipment is Covered when required for therapeutic use, determined to be Medically Necessary by the Member's Provider/Practitioner and if Certified by PIC. 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 the 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

(6) Repair and replacement due to normal wear, loss, neglect, damage, theft, misuse, abuse, to improve appearance, or for convenience or items under the manufacturer's or supplier's guarantee.

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

d. Home sleep studies.

Durable Medical Equipment is subject to a Calendar Year Maximum when received from Non-participating Providers/Practitioners. Refer to your *Schedule of Benefits* for the amount of this maximum.

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 Provider/Practitioner and if Certified by PIC. **Foot Orthotics or shoe appliances are not Covered**, except for Members with diabetic neuropathy or other significant neuropathy. Custom fabricated knee-ankle-foot orthoses (AFO and/or KAFO) are Covered for Members up to eight years old.

Orthotic appliances are subject to a Calendar Year Maximum when received from Non-participating Providers/Practitioners. Refer to your *Schedule of Benefits* for the amount of this maximum.

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 Provider/Practitioner and when Certified by PIC.

Prosthetic devices are subject to a Calendar Year Maximum when received from Non-participating Providers/Practitioners. Refer to your *Schedule of Benefits* for the amount of this maximum.

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

4. **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 Provider/Practitioner 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 Provider/Practitioner's office or by a home health professional.

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

(3) Elastic support hose.

5. **Eyeglasses and Contact Lenses (Limited)**

All eyeglasses or contact lenses are **subject to the limitations listed in the Limitations section and the exclusions listed in the Exclusions section** of this Agreement. **The following will only be Covered if received from Participating Providers/Practitioners**.

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 eyeglasses and contact lenses:**

(1) Except as above, routine vision care, Eye Refraction, 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.

6. **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.

K. Family, Infant, and Toddler (FIT) Program

Coverage for children, from birth to age three, for or under the Family, Infant and Toddler (FIT) program administered by the Department of Health, provided eligibility criteria are met, is provided for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in 7.30.8 NMAC. 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.

L. 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 the Limitations section, the exclusions listed in the Exclusions section and the Benefit Certification requirements listed in the Benefit Certification section** of this Agreement. Medical services provided by licensed healthcare professionals, including Provider/Practitioners, 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 PIC's** pharmacy department.

Special Medical Foods are Covered when prescribed by a Provider/Practitioner for treatment of Genetic Errors of Metabolism, and the Member is under the Provider/Practitioner'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 Provider/Practitioner'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/Co-insurance**

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

M. 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**. A Home Health Agency will provide home intravenous services and supplies at a Member's home when Certified by PIC and when prescribed by the Member's Provider/Practitioner. Any such prescription or Benefit Certification must be renewed at the end of each 60-day period. PIC will not impose a limitation on the number of related hours per visit.

1. Home Healthcare services shall include Medically Necessary skilled intermittent healthcare services provided by a registered nurse or a licensed practical nurse, physical, occupational, and/or respiratory therapist and/or speech pathologists. Such services may include collection of specimens to be submitted to an approved

laboratory facility for analysis. 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, laboratory services and supplies deemed Medically Necessary by a Provider/Practitioner 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 Provider/Practitioner and as approved by PIC.

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

5. Medical Drugs: These are drugs that are administered by a healthcare professional as part of the Home Healthcare Services. These drugs can be oral or injectable, and some will require Benefit Certification prior to being administered/provided. For a complete list of these drugs, please see the Medical Drug listing online at www.phs.org.

N. Hospice Care (Where a certified Hospice program is available)

Hospice services are limited to a Lifetime maximum. Refer to your *Schedule of Benefits* for this maximum.

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 PIC 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 Hospice or other facility when approved by the Member's Provider/Practitioner and Certified by PIC. The Hospice benefit period must begin while the Member is enrolled in this plan, and Coverage through PIC 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 Provider/Practitioner 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 Provider/Practitioner must re-certify the Member's medical condition to PIC. No more than one additional Hospice benefit period will be Certified by PIC.

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

   a. Inpatient Hospice care;

   b. Provider/Practitioner visits by Participating Hospice Provider/Practitioners;

   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 Deductible and Co-insurance requirements:

   a. acute Inpatient Hospital care for curative services;

   b. Durable Medical Equipment;

   c. Provider/Practitioner visits by other than a Hospice Provider/Practitioner; and

   d. Ambulance Services.

6. Where there is not a certified Hospice program available, regular Home Healthcare Services benefits will apply. Refer to the Benefits section item M. (Home Healthcare Services/Home Intravenous Services and Supplies) of this Agreement.

7. **Hospice services are limited to a Lifetime maximum. Refer to your *Schedule of Benefits* for this maximum.**

O. 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 PIC, unless such services constitute Emergency Health Services. Hospital services must be provided under the direction of the Member's Provider/Practitioner.

Inpatient Hospital services include, but are not limited to, the following when Medically Necessary, **subject to the Benefit Certification requirements listed in the Benefit Certification section, the limitations listed in the Limitations section and the exclusions listed in the Exclusions section:**

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. **Detoxification in a Residential Treatment Center is not Covered**. Acute Medical detoxification treatment must be approved in advance by the Member's Provider/Practitioner and must be Certified by PIC. **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 the Benefits section item I. (Diagnostic Services).
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. Provider/Practitioner and surgeon services.
9. Private room and board accommodations when Medically Necessary and Certified by PIC.
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 PIC.

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

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

P. Nutritional Support and Nutritional Supplements

1. 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.

2. 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**.

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

4. 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.**

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

6 Special Medical Foods as listed as Covered in item L. 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 attending Provider/Practitioner**, subject to the Benefit Certifications listed in the Benefit Certification section, the limitations listed in the Limitations section and the exclusions listed in the Exclusions section of this Agreement.** Such services may be provided in a Hospital, Provider/Practitioner'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 Law.

1. Anesthetics, oxygen, drugs, medications.

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

3. Chemo and radiation therapy.

4. Detoxification: Medically Necessary services for Substance Abuse detoxification.

5. Diagnostic Services, as specified in t he Benefits section item I. (Diagnostic Services).

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

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

8. Medical Drugs: These are prescription drugs that are administered/provided in the Provider's/Practitioner's office or in an Outpatient facility. These drugs can be oral or injectable, and some may require Benefit Certification prior to being administered/provided. These drugs are subject to a separate Copayment to a maximum as outlined in your Schedule of Benefits. These drugs are also subject to a Calendar Year Out-of-pocket Maximum when provided by a Participating Provider/Practitioner. The Medical Drugs Out-of-pocket Maximum is separate from the Plan's Annual Calendar Year Out-of-pocket maximum. For a complete list of these drugs, please see the Medical Drug listing at www.phs.org.

9. 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 PIC must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status. Medical criteria will also be considered. Observation greater than 24 hours will require Benefit Certification.

10. Home/Outpatient sleep disorder studies are Covered when provided by Participating Providers/Practitioners only and are subject to the Calendar Year maximum listed on your Schedule of Benefits.

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

12. Therapeutic and support care services, supplies, appliances, and therapies.

R. Provider/Practitioner Services

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

1. a licensed Provider/Practitioner,

2. by other health professionals who are licensed to practice, are certified, and are practicing as authorized by applicable law or authority,

3. a medical group,

4. an independent practice association, or

5. other authority authorized by applicable state Law.

The Provider/Practitioner services**,** Covered by this Section are **subject to the Benefit Certification requirements listed in the Benefit Certification section, the limitations listed in the Limitations section and the exclusions listed in the Exclusions section of this Agreement.** This Agreement covers consultation, healthcare services and supplies provided by the Member's Provider/Practitioner including:

1. Office visits provided by a qualified Provider/Practitioner.

   "Telephone visits" and Electronic mail (E-mail) by a Provider/Practitioner or "consultation" by telephone for which a charge is made to the patient is not Covered except for members who have been diagnosed with diabetes. Also, "get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided are not Covered.

2. Home Visits, if Medically Necessary.

3. Outpatient surgery and Inpatient surgery including necessary anesthesia services by a qualified Provider/Practitioner.

4. Hospital and skilled nursing home visits by Provider/Practitioners as part of continued supervision of Covered care.

5. Allergy Immunotherapy, including testing and sera.

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

7. Family planning services:

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

   b. Sterilization procedures. **Reversal of voluntary sterilization is not Covered**.

   c. **Elective abortions are not Covered.**

   d. **Infertility Services/Artificial conception including but not limited to diagnosis, treatment drugs and injections, artificial insemination, donor sperm, In-vitro, GIFT and ZIFT fertilization is not Covered.**

8. Second medical opinions. **The office visit Deductible and Co-insurance will apply when the Member or the Provider/Practitioner requests the second opinion.** The office visit Deductible and Co-insurance will not apply if PIC requires a second opinion to evaluate the medical appropriateness of a diagnosis or service.

S. Covered Medications (Outpatient)

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

   a. Insulin and diabetic oral agents for controlling blood sugar levels as prescribed by your Provider/Practitioner for a 30-day supply up to the maximum dosing recommended by the manufacturer. Refer to your *Schedule of Benefits* for the Co-insurance amount.

   b. Immunosuppressive Drugs (Oral) following transplant surgery as prescribed by your Provider/Practitioner for a 30-day supply up to the maximum dosing recommended by the manufacturer. Refer to your *Schedule of Benefits* for the Co-insurance/Lifetime Maximum amounts.

   c. Specialty Pharmaceuticals These are medications that are self-administered meaning they are administered by the patient or to the patient by a family member or care-giver. These medications are obtained thru the pharmacy benefit. These drugs can be oral or injectable, and will require Benefit Certification prior to being administered/provided. These drugs are subject to a separate Copayment to a maximum as outlined in your *Schedule of Benefits*. These drugs are also subject to a Calendar Year Out-of-pocket Maximum when provided by a Participating Provider/Practitioner. The Specialty Pharmaceutical Out-of-pocket Maximum is separate from the Plan's Annual Out-of-pocket Maximum. For a complete list of these drugs, please see the Specialty Pharmaceutical listing at www.phs.org. You can call the Presbyterian Customer Services Center at **(505) 923-6980**, toll-free **1-800-923-6980**. TTY users may call **(505) 923-5699** or toll-free **(877) 298-7407.**

   d. Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status when Certified by Presbyterian Insurance Company, Inc.'s pharmacy department. Refer to item L. (Genetic Inborn Errors of Metabolism - IEM) of this Section and your *Schedule of Benefits* for more information, exclusions and Deductible and Co-insurance amounts.

   e. Smoking Cessation Pharmacotherapy. Prescription Drugs as prescribed by your Provider/Practitioner for a 30-day supply up to the maximum dosing recommended by the purchased at a Participating Pharmacy **limited to two 90-day courses of treatment per Calendar Year**. Refer to "Covered Medications" in your *Schedule of Benefits* for Deductible and Co-insurance amounts.

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 medications at a PIC Participating Pharmacy. Under the 90-day at Retail pharmacy benefit, Preferred and Non-Preferred 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 maximum dosing recommended by the manufacturer. Copayments are as follows:

Generic(Preferred)	3 x Generic copay
Brand (Preferred)	3 x Preferred brand copay
Non-Preferred Brand	3 x Non-Preferred copay

4. **Over-the-Counter (OTC) medications**

   The following benefit is only for those prescription medications as identified in this plan as Covered. When a prescription medication is available at an equivalent dose Over-the-Counter (OTC), PIC will cover the OTC version if it is a cost-effective option. **A prescription is required for approved OTC medications and is subject to the Generic Copayment.** The Member must purchase the approved OTC medications directly from a PIC Participating Pharmacy. **If an approved OTC medication is not purchased directly from a pharmacist at a PIC Participating Pharmacy, then the OTC medication will not be Covered.** Approved OTC medications are subject to change as determined by PIC's Pharmacy and Therapeutics Committee. Refer to the PIC Preferred Drug List for the Covered OTC medications. This listing is available on our website at www.phs.org.

5. **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 PIC's Pharmacy and Therapeutics Committee. Refer to the PIC Preferred Drug List to locate approved mediations for tablet splitting. This listing is available on our website at www.phs.org.

6. **Mail Order Pharmacy**

Members have a choice of obtaining certain Prescription Drugs directly at Participating Pharmacies or by ordering them through the mail. Under the mail order pharmacy benefit, Preferred and non-Preferred medications can be obtained through the Mail Service Pharmacy. Members may purchase a 90-day supply up to the maximum dosing recommended by the manufacturer. You may obtain the name of the Mail Service Pharmacy by calling our Customer Service Center at **(505) 923-6980** or **1-800-923-6980,** Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407** or visit our website at www.phs.org. 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 Brand	3 x Non-Preferred copayment

T. Prescription Drug Benefit (Outpatient)

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 Co-insurance amount for these services.

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 oral contraceptives and devices**,** are a Covered Benefit **only when obtained from a Participating Pharmacy**, unless required due to an emergency occurring outside of the Service Area, and when prescribed by the Member's Provider/Practitioner for a medically appropriate use.

   For each Prescription Drug purchased at a PIC Participating Pharmacy, one applicable generic (Preferred), brand (Preferred) or Non-Preferred Co-insurance 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 Provider/Practitioner requests the brand name in place of the generic, the Member will be responsible for payment of the generic Co-insurance plus the difference in the cost (if any) between the generic and brand drug.

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

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

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

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

d. Specialty Pharmaceuticals: These are medications that are self-administered meaning they are administered by the patient or to the patient by a family member or care-giver. These medications are obtained thru the pharmacy benefit. These drugs can be oral or injectable, and will require Benefit Certification prior to being administered/provided. These drugs are subject to a separate Copayment to a maximum as outlined in your *Schedule of Benefits*. These drugs are also subject to a Calendar Year Out-of-pocket Maximum when provided by a Participating Provider/Practitioner. The Specialty Pharmaceutical Out-of-pocket Maximum is separate from the Plan's Annual Out-of-pocket Maximum. For a complete list of these drugs, please see the Specialty Pharmaceutical listing at www.phs.org. You can call the Presbyterian Customer Services Center at **(505) 923-6980**, toll-free **1-800-923-6980**. TTY users may call **(505) 923-5699** or 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 medications at a PIC Participating Pharmacy. Under the 90-day at Retail Pharmacy benefit, Preferred and non-Preferred 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 maximum dosing recommended by the manufacturer. Copayments are as follows:

Generic(Preferred)	3 x Generic copay
Brand (Preferred)	3 x Preferred brand copay
Non-Preferred Brand	3 x Non-Preferred copay

4. **Over-the-Counter (OTC) medications**

The following benefit is only for those prescription medications as identified in this plan as Covered. When a prescription medication is available at an equivalent dose Over-the-Counter (OTC), PIC will cover the OTC version if it is a cost-effective option. **A prescription is required for approved OTC medications and is subject to the Generic Copayment.** The Member must purchase the approved OTC medications directly from a PIC Participating Pharmacy. **If an approved OTC medication is not purchased directly from a pharmacist at a PIC Participating Pharmacy, then the OTC medication will not be Covered.** Approved OTC medications are subject to change as determined by PIC's Pharmacy and Therapeutics Committee. Refer to the PIC Preferred Drug List for the Covered OTC medications. This listing is available on our website at www.phs.org.

5. **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 PIC's Pharmacy and Therapeutics Committee. Refer to the PIC Preferred Drug List to locate approved mediations for tablet splitting. This listing is available on our website at www.phs.org.

6. **Mail Order Pharmacy**

Members have a choice of obtaining certain Prescription Drugs directly at Participating Pharmacies or by ordering them through the mail. Under the mail order pharmacy benefit, Preferred and non-Preferred medications can be obtained through the Mail Service Pharmacy. Members may purchase a 90-day supply up to the maximum dosing recommended by the manufacturer. You may obtain the name of the Mail Service Pharmacy by calling our Customer Service Center at **(505) 923-6980** or **1-800-923-6980,** Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407** or visit our website at www.phs.org. 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 Brand	3 x Non-Preferred copayment

Member Reimbursement for Out-of-Area

If a medical emergency occurs outside of the PIC Service Area and the Member uses a Participating Pharmacy, the Member will be responsible for payment of the appropriate Co-insurance. 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 PIC for reimbursement. If approved, the reimbursement will be based on the Reasonable and Customary Charge subject to the applicable Co-insurance 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 Provider/Practitioner;

e. name and phone number of pharmacy;

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

g. proof of payment.

Exclusions related to Prescription Drugs

a. Prescription Drugs that require a Benefit Certification when Benefit Certification was not obtained.

b. Prescriptions purchased at a Non-participating Pharmacy unless required due to an emergency occurring outside of the Service Area.

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

d. Compounded 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 *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 PIC determines are Experimental or Investigational.

h. Disposable medical supplies, except when provided in a Hospital or a Provider/Practitioner'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. Infant formula and nutritional supplements unless for prenatal care as prescribed by the attending Provider/Practitioner or as sole source of nutrition.

k. Medications used for the treatment of sexual dysfunction.

l. Medications used for cosmetic purposes.

m. Medications used for the treatment of infertility.

n. Medications considered Mental Health medications.

o. New Medications for which the determination of criteria for Coverage has not yet been established by PIC's Pharmacy and Therapeutics Committee.

U. Reconstructive Surgery

Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be provided if performed for the correction of functional disorders. The Member's Provider/Practitioner must prescribe Reconstructive Surgery and

Certification from PIC must be obtained. For information regarding Reconstructive Surgery following a Mastectomy refer to item Z. (Women's Healthcare) of this Section.

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.

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.

2. Pulmonary Rehabilitation Services. Coverage is provided for 24 sessions of progressive exercises and monitoring of pulmonary functions per Member per Calendar Year when Certified by PIC.

3. Short-Term Rehabilitation Services. Short-Term Rehabilitation benefits are available for physical therapy and occupational therapy, provided in a Rehabilitation Facility, Skilled Nursing Facility, Home Health Agency, or outpatient setting. Short-Term Rehabilitation is designed to assist Members in restoring functions that 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. The Member's Provider/Practitioner 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 Provider/Practitioner 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 PIC, 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, Inpatient or outpatient Short-Term Rehabilitation Services may be extended upon recommendation of the Member's Provider/Practitioner in consultation with PIC, if Medically Necessary and if Certified by PIC.

      Extension of Short-Term Outpatient Rehabilitation beyond the initial two months will be certified for one additional two month period only if such services can be expected to result in continued Significant Improvement of a Member's physical condition within a period of two months. 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 PIC benefit plan, this benefit 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, and Cerebral Palsy.

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

f. **Athletic trainers are not Covered**.

4. Outpatient 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 Member's Provider/Practitioner must determine in advance, in consultation with PIC, 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 PIC.

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

(1) Certified by PIC; and

(2) the Member's Provider/Practitioner in consultation with PIC 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 except for school-aged children under 18 years old (or under 21 years of age if still attending high school).**

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

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

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 PIC and by the Member's Provider/Practitioner. 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 non-specialist or specialist Co-insurance 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 limits or visit maximums. The non-specialist or specialist Co-insurance applies 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 our Customer Service Center at **(505) 923-6980** or toll-free at **1-800-923-6980**, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407** 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 Deductible and Co-insurance 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 F. (Complementary Therapies) of this Section for Benefits available under the Acupuncture Benefit.

Y. Transplants

1. Human Organ transplant benefits are available for cornea, heart, heart/lung, lung, intestinal, kidney, liver, pancreas, and pancreas islet cell infusion. Bone marrow transplants are Covered **only for leukemia, aplastic anemia, lymphoma, severe combined immunodeficiency 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 PIC and be Certified by PIC.

4. All Organ transplants must also be deemed Medically Necessary by the Member's Provider/Practitioner. **Transplant services shall be performed at a site approved by PIC**.

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 PIC 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. PIC will pay the Total Allowable Charges for a donor who is not entitled to benefits under any other health benefit plan or policy.

7. **Transplant services received from Non-participating Providers/Practitioners are not Covered.**

Z. Women's Health Care

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

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

1. Gynecological care includes annual exams, miscarriage, therapeutic abortions, and other gynecological services.

2. **Prenatal and Maternity Care are not Covered.**

   Services related to prenatal, postnatal and Maternity care are not Covered under this Agreement including, but is not limited to, visits to an Obstetrician, certified nurse-midwife, or licensed-midwife, pregnancy related diagnostic tests, home births, Durable Medical Equipment or other pregnancy related devices. **Voluntary termination of pregnancy is not Covered except for a**

missed abortion. **Hospitalization for the delivery of a child is not Covered in this Agreement.**

3. Complications of Pregnancy. Certain complications of pregnancy are Covered if services are Certified by PIC. Complications of pregnancy that are Covered under this Agreement include conditions (when the pregnancy is not terminated) that are distinct from the pregnancy, but are affected by pregnancy or caused by pregnancy, such as, but not limited to, acute nephritis, nephrosis, cardiac decompensation, gestational diabetes, pregnancy-induced hypertension, missed abortion, life threatening or massive bleeding and similar medical and surgical conditions of comparable severity; and ectopic pregnancy.

   Complications of pregnancy that are not Covered under this Agreement include, but are not limited to, false labor, elective and non-elective Cesarean Section, multiple gestation, non-life threatening bleeding or occasional spotting, Provider/Practitioner prescribed rest during the period of pregnancy, morning sickness, and fetal conditions affecting management of the mother, such as, but not limited to, fetal care fetal surgery, and complications of the fetus or fetal demise.

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

   a. the signed and completed Enrollment Application form must be received by PIC within 31 days from the date of birth. If the Application is not received by PIC within 31 days of birth, a health statement will be required. The request for Coverage may be denied in such cases; and

   b. the applicable Prepayment must be paid to PIC within the first 31 days following the date of birth for the newborn to be Covered.

   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**.** This Dependent can apply for separate Individual Coverage.

   c. Neonatal care is available for the newborn child **(if enrolled)** 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 (if enrolled) 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 Provider/Practitioner,

circumcision, incubator, and routine Hospital nursery charges. **Circumcisions performed other than during the newborn's Hospital stay are only Covered when Medically Necessary.**

5. Cytologic screening (Pap smear), Human Papillomavirus (HPV) screenings, HPV Vaccine coverage *in accordance with all applicable state and federal requirements and the guidelines established by* The Advisory Committee on Immunization Practices (ACIP), and mammography. *Coverage* is described in the Benefits Section of this Agreement.

6. The Alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks for pregnancy, to screen for certain genetic abnormalities in the fetus.

7. Mastectomy, Prosthetic Devices and Reconstructive Surgery. 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 Provider/Practitioner 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 the Deductible and Co-insurance** 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 Calendar Year are Covered for Member's with external breast prosthesis. **All care must be provided by or under the direction of the Member's Provider/Practitioner and with appropriate Benefit Certification from PIC.**

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 the Member's Provider/Practitioner in consultation with PIC.

V. DENTAL

Please refer to:

The Delta Dental Summary of Benefits for an outline of your dental coverage.

Also refer to:

Exhibit B for information on how to access dental benefits information online
and print a personalized Delta Dental ID Card
And
Exhibit C for the Dental Benefits Handbook

Your dental plan is underwritten and administered by Delta Dental of New Mexico.
Should you have questions about your dental benefits or a claim, please contact
Delta Dental Benefit Services at:

(505) 883-4777 or, if calling from outside Albuquerque, **1-800-999-0963**

www.deltadentalNM.com

VI. BENEFIT CERTIFICATION

Certain healthcare services require Certification. This Section explains what 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 Insurance Company, Inc. (PIC) or PIC's delegated Provider/Practitioner contractor reviews and approves in advance the provision of certain Covered Benefits to Members before those services are rendered. Benefit Certifications are granted for specific providers and specific services as requested. Services rendered beyond the scope of the Benefit Certification are not Covered, providers and members must coordinate accordingly. **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**.

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 PIC Medical Director or the Medical Director's designee.

When accessing Out-of-network Benefits, you are responsible for obtaining Benefit Certification from PIC or PIC's designee before obtaining the Out-of-network Services. **If Benefit Certification is not obtained when required, then the services will not be Covered by PIC and payment will be your responsibility.**

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

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, Provider/Practitioner participation, state and federal regulations, and PIC's own policies and procedures. Your Participating Provider/Practitioner will know when Benefit Certification is necessary. **It is your responsibility to request Benefit Certification for the following services if they are to be received from a Non-participating Provider/Practitioner.** Check with your Participating Provider/Practitioner or PIC to verify the need for Benefit Certification. The following services and supplies require Benefit Certification:

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 the Benefits Section item D. (Cancer Clinical Trials) of this Agreement.

4. Computed Axial Tomography (CAT) scans;

5. detoxification;

6. Durable Medical Equipment;

7. foot Orthotics, as specified in the Benefits section item J. (Durable Medical Equipment) of this Agreement;

8. home health services/home health intravenous drugs;

9. Hospice care;

10. Hospital admissions, Inpatient non-emergent;

11. injectable drugs, (includes Specialty Medications and home health intravenous drugs) except as noted in the Benefits section of this Agreement;

12. insulin pumps;

13. Investigational/Experimental services;

14. Magnetic Resonance Imaging (MRI) tests.

15. Observation greater than 24 hours;

16. Organ transplants;

17. Orthotics;

18. PET (Positron Emission Tomography) scans;

19. Prescription Drugs: Refer to the Benefits section items S. (Covered Medications) and T. (Prescription Drug Benefit - Outpatient) of this Agreement;

20. Prosthetics;

21. reconstructive and potentially cosmetic procedures;

22. Selected Surgical/Diagnostic procedures;

23. Skilled Nursing Facility care;

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

25. Speech/hearing therapy;

26. Transplants.

If a request for a Benefit Certification is made and not approved, PIC will notify a member and the requesting provider of the adverse determination by telephone (or as required by the medical exigencies of the case), within twenty-four (24) hours after making the determination. PIC will also notify the member and provider of the adverse determination by written or electronic communication sent within one (1) working day of a telephone notice.

Please see "Complaints, Grievances and Appeals" Section for information regarding the request for internal review of any adverse determinations made by PIC.

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

VII. 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. GENERAL INFORMATION SECTION;

2. BENEFITS SECTION;

3. BENEFIT CERTIFICATION SECTION; AND

4. EXCLUSIONS SECTION OF THIS AGREEEMENT.

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 Insurance Company, Inc. (PIC), 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 PIC's control, PIC shall render or attempt to arrange Covered Benefits with Participating Providers/Practitioners insofar as practical, according to its best judgment, and within the limitations of facilities and personnel as are then available. However, no liability or obligation shall result from nor shall be incurred for the delay or failure to provide any such services due to the lack of available facilities or personnel, if such lack is the result of such disaster, epidemic or other circumstances beyond PIC's control and if PIC 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, PIC personnel or Participating Providers/Practitioners or similar causes. This provision does not impose any limitation on the availability of Coverage for services provided by Non-participating Providers/Practitioners.

C. Organ Transplants. Organ transplants are limited to those procedures and benefits described in the Benefits section item Y. (Transplants).

D. Benefit Certification. Availability of certain services and supplies are subject to Benefit Certification as specified in the Benefit Certification section.

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

F. Pre-existing Conditions. This plan is subject to Pre-existing Condition limitations, unless the Pre-existing Condition limitation can be offset by prior Coverage. Refer to the General Information section item G. (Pre-existing Conditions Limitation) for more details.

VIII. EXCLUSIONS

This Section lists services that are not Covered under your benefit plan. Any exclusion listed would not be applicable if covered under Senate Bill 589 as defined in Title 7, Chapter 30, Part 8 Health Family and Children Health Care Services. Refer to the Benefits section item J. (Family, Infant and Toddler (FIT) Program).

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

1. GENERAL INFORMATION SECTION;

2. BENEFITS SECTION;

3. BENEFIT CERTIFICATION SECTION; AND

4. LIMITATIONS SECTION.

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.**

C. **Alternative/complementary therapies**, except as specified in the Benefits section item F. (Complementary Services) of this Agreement and only if received through a Participating Provider/Practitioner.

D. **Artificial aids** including speech synthesis devices (except items identified as being Covered in the Benefits section item J. (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 detoxification.
2. **Mental Health Services** including medications.
3. **Halfway houses.**

4. **Residential Treatment Centers.**

5. **Co-dependency treatment.**

6. **Counseling:** sex, pastoral/spiritual, and bereavement counseling.

7. **Psychological testing.**

8. **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 covered under the Family, Infant and Toddler Program. Refer to the Benefits section item K.

I. All other benefits and services not specifically listed as Covered Benefit (Section IV) shall be excluded.

J. Biofeedback.

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 indicated in the Benefits section item D. of this Agreement.

2. Costs of the Cancer 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 Insurance Company, Inc. (PIC) and provided for in New Mexico.

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

5. The cost of 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 Cancer 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 PIC and charges in excess of Reasonable and Customary Charges.

O. **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.

P. **Convenience items:** 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/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 Benefits).

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

R. **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.

S. **Cosmetic treatments**, devices, Orthotics, and medications**,** including treatment of hair-loss.

T. **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.

U. **Custodial or Domiciliary Care.**

V. Exclusions relating to **Dental Services**:

1. **Dental care** and dental x-rays, except as provided in the Benefits section item G. (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 PIC.**
2. **Dental implants.**
3. **Malocclusion treatment,** if part of routine dental care and orthodontics.
4. **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures.**
5. **Orthodontic appliances and treatment** (braces), crowns, bridges and dentures used for the treatment of Cranio/Temporomandibular Joint disorders, unless the disorder is trauma related.

W. **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 Provider/Practitioner's office or by a home health professional.

X. Exclusions relating to **Durable Medical Equipment:**

1. **Duplicate Durable Medical Equipment** items (i.e. for home and office).
2. **Functional foot Orthotics** including those for plantar fasciitis, pes planus (flat feet), heel spurs and other conditions (as determined by PIC). 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.
3. 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.
4. **Upgraded or deluxe Durable Medical Equipment**.
5. Additional **wheelchairs**, if the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair.
6. **Repair or replacement of Durable Medical Equipment,** Orthotic Appliances and Prosthetic Devices due to normal wear, loss, neglect, damage, theft, misuse, abuse, to improve appearance or convenience.
7. **Repair and replacement** of items under the manufacturer of supplier's warranty.

Y. **Elastic Support hose**.

Z. **Exercise Equipment** and videos, personal trainers, club membership and weight reduction programs.

AA. **Expenses due to medical travel (Food/Lodging)**.

AB. Drugs, medicines, treatments, procedures, or devices that PIC 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 approved 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 Cancer Clinical Trials, except as specified in the Benefits section item D. (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.

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

AD. Exclusions relating to **Genetic Inborn Errors of Metabolism;**

1. Food substitutes for lactose intolerance including soy foods or formulas or other over the counter digestive aids.
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 required a Provider/Practitioner'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.
9. Special Medical Foods for conditions including, but not limited to: Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, and Allergies to food products.

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

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

AG. **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)**.

AH. **Home sleep studies.**

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

1. food, housing, and delivered meals; or
2. volunteer services; or
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); or
4. homemaker and housekeeping services; or
5. pastoral and spiritual counseling; and

6. bereavement counseling.

AJ. **Hypnotherapy**.

AK. **Infertility Services/Artificial conception** including, but not limited to, diagnosis, treatment drugs and injections, artificial insemination, donor sperm, In-vitro, GIFT and ZIFT fertilization.

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

AM. **Maternity Benefits** including, but not limited to, any condition which is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and postnatal care.

AN. **A newborn of a Member's Dependent child** is not Covered as a Dependent on this Member's Contract unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by a court as the newborn's legal guardian. This Dependent can apply for separate Individual Coverage.

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

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

AQ. **Nutritional supplements**.

AR. 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.

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

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

AU. **Photopheresis** for all conditions other than mycosis fungoides.

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

AW. Exclusions Relating to Prescription Drugs:

1. **Compounded prescriptions.**
2. **Over-the-Counter (OTC) medications** and drugs for which there is a non-prescriptive equivalent available with the exception of approved OTC medications as determined by PIC's Pharmacy and Therapeutics Committee. Refer to the PIC Preferred Drug Listing for a list of Covered OTC medications.
3. **Medications** considered mental health medications.

4. **Prescription Drugs** received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available.

5. **Prescription Drugs** that require a Benefit Certification when Benefit Certification was not obtained.

6. **Prescriptions** purchased at a Non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area.

7. **Replacement prescriptions** resulting from loss, theft, or destruction.

8. **Prescription Drug Coinsurance Costs.**

AX. Hospital, Provider/Practitioner, mid-wife and other charges related to **prenatal care and delivery** of a newborn.

AY. **Private duty nursing.**

AZ. **Reversals of voluntary sterilization.**

AAA. **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.

AAB. 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.

AAC. **Services requiring Benefit Certification** when Benefit Certification was not obtained. (Member's are not liable when a Participating Provider/Practitioner does not obtain Benefit Certification).

AAD. **Sex transformation** surgery and drugs related to sex transformation.

AAE. Treatment for **sexual dysfunction**, including medication, counseling, and clinics, except for penile prosthesis as listed under the Benefits section item J. (Durable Medical Equipment) of this Agreement.

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

AAG. **"Telephone visits" and Electronic mail (E-mail) by a Physician Provider/Practitioner or "consultation" by telephone for which a charge is made to the patient is not Covered except for members who have been diagnosed with diabetes. Also, "get acquainted" visits without physical assessment, diagnostic, or therapeutic intervention provided are not Covered.**

AAH. **Transportation costs** for deceased Members.

AAI. **Travel and lodging expenses** except as provided in the Benefits section item Y. (Transplants) of this Agreement.

AAJ. 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 Refraction for determining prescriptions for corrective lenses, except as identified in the Benefits section item J. (Durable Medical Equipment) of this Agreement.
4. **Visual training**.

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

AAL. **Weight reduction or control treatments and medications**, except for Medically Necessary treatment for morbid obesity.

AAM. **This plan does not cover** a work-related illness or injury even if:

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

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

AAO. **Medically Necessary Nutritional Supplements for prenatal care.**

PIC shall not be obligated to provide any services under this Agreement on or after the effective date of termination of this *Subscriber Agreement*. See the Termination section.

IX. 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 that may allow you to change your benefit elections..

A. Who is Eligible?

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

   a. physically live in Presbyterian Insurance Company, Inc.'s (PIC) Service Area as defined in Exhibit A of this Agreement; and

   b. be under the age of 65.

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

   a. be your **legally married spouse**, as defined by state law and

      (1) physically live in **PIC's Service Area** as defined by PIC in Exhibit A of this Agreement; and

      (2) be under the age of 65; or

   b. be your **Dependent child** who is:

      (1) under 26 years of age;

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

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

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

      Enrollment of a Dependent child under this Contract shall terminate at the end of the month upon attainment of the child's 26th birthday except as provided in 2.d. below; or

   c. be your or your spouse's Dependent child, under 26 years of age for whom you are required by court or qualified administrative 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 the General Information section item C. Enrollment of a Dependent child under this Contract shall terminate at the end of the month upon attainment of the child's 26th birthday.

   d. The attainment of the child's 26th birthday shall not terminate the Coverage of a Dependent under this Agreement if he/she is an unmarried child who is **totally and permanently disabled** and is both 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 PIC within 31 days of the Dependent child's attainment of age 26**, and each birthday thereafter if requested and approved by PIC.**

3. No person shall be eligible to enroll who has had a prior PIC Contract terminated for Good Cause as outlined in the Termination section of this Agreement or any similar Sections of other PIC Contracts, unless approved in writing by PIC.

4. HSA Note: For the purposes of establishing a Health Savings Account, you are reminded that an eligible individual means, with respect to any month, any individual who:

   a. is covered under a Qualified High Deductible Health Plan (HDHP);

   b. is not also covered by any other health plan that is not a qualified HDHP (with certain exceptions for plans providing certain limited types of coverage);

   c. is not entitled to benefits under Medicare (generally, has not reached age 65); and

   d. may not be claimed as a Dependent on another person's tax return.

   Please see the Effect of Other Coverage section for further eligibility information or contact your HSA administrator or financial institution.

B. Enrollment and Effective Dates

Eligible Subscribers and Dependents may apply for Coverage by submitting completed Application forms to Presbyterian Insurance Company, Inc., PO Box 26267, Albuquerque, New Mexico, 87125-6267:

1. This benefit plan is medically underwritten. Subscribers and eligible Dependents may begin receiving services for Covered Benefits at 12:01 a.m. on the first of the month following approval of medical review by PIC 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 PIC;

   b. the appropriate advance Prepayment has been received by PIC for the Subscribers and eligible Dependents; and

   c. All submission deadlines have been met.

2. A Subscriber's newly acquired spouse (and any child of the spouse eligible for Coverage under item A.2.b. of this Section) may be eligible to be enrolled as a Dependent. Such newly acquired spouse (and any child of the spouse eligible) must submit an Application and health statement **within 31 days** from the date of

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

marriage. Coverage may be denied. If approved, Coverage will become effective on the first day of the month following the date of marriage. Newborn children of a Subscriber or Subscriber's spouse will be Covered from moment of birth when enrolled as follows:

a. the signed and completed Enrollment Application form must be received by PIC **within 31 days** from the date of birth.

b. the applicable Prepayment must be paid to PIC **within the first 31 days** following the date of birth for the newborn to be Covered.

c. If the notification of birth and any applicable Prepayment are not received by PIC **within 31 days** of birth, then coverage for the newborn will begin no the first day of the month following receipt of the notification of birth and any applicable Prepayment.

3. 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 the applicable Prepayment is received by PIC **within 31 days** of the date of placement. The term "placement" as used in this item 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. 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** 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.

5. A child for whom a Subscriber has been ordered by a court of law/qualified administrative order to provide healthcare Coverage, is eligible to be enrolled as a Dependent, provided that the Subscriber is eligible for family Coverage and the request for enrollment is made **within 31 days** from the date on which the Subscriber receives the court or qualified administrative order. The Dependent will become a Member on the day stipulated by the court or qualified administrative order.

6. Grandchildren are not eligible for Coverage under this plan unless the Subscriber has adopted the grandchild, or is the legal guardian or has been ordered by a court of law or qualified administrative order to provide healthcare coverage for the grandchild as identified in items 4, 5, and 6 above. This includes, but is not limited to, children of non-custodial children.

7. **If an Application and any applicable Prepayment for a newly acquired child is not received by PIC within 31 days** of adoption or legal guardianship as identified above, coverage for the newly acquired child will not begin until the first day of the month following receipt of the Application and any applicable Prepayment.

C. Continuation of Coverage

A Dependent(s) may transfer to a separate individual policy without further proof of insurability or additional Pre-existing Limitation requirements if a Dependent(s) loses eligibility due to any of the following involuntary events:

1. divorce, annulment or dissolution of a marriage, or legal separation of the spouse from the Subscriber;
2. the 26th birthday of a Dependent child;

Coverage will be continued if a notice of change and applicable Prepayment is received by PIC within 31 days of the qualifying event, however, the plan must remain the same as the original plan issued. If the notice of change is not received within 31 days of the qualifying event, this transfer of Coverage will not be available. The Member may, however apply for new Coverage, and if approved by medical underwriting, Coverage will become effective the first of the month following approval and receipt of Prepayment.

In the event of the death of the Subscriber, Coverage for enrolled Dependents will be continue without further proof of insurability as long as Prepayments are continued. Please contact PIC for the appropriate paperwork required for this continuation of Coverage.

Continuation of Coverage is not available when the terminating Member resides outside of the PIC Service Area.

X. 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

A. Notice of claim.

Written notice of claim must be given to Presbyterian Insurance Company, Inc**.,** (PIC) within 20 days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

B. Claim Forms

Upon receipt of a notice of claim, PIC will furnish the forms needed for filing proof of loss. Forms will be furnished within 15 days after PIC's receipt of such notice.

C. Participating Providers/Practitioners

PIC 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 Deductible, Copayment (Mail Order Pharmacy), and Co-insurance amounts. Members will be responsible for payment of charges for missed appointments or appointments canceled without adequate notice. If a Member is asked by a Participating Provider/Practitioner to make any Deductible, Copayment (Mail Order Pharmacy) or Co-insurance in addition to those specified in this Agreement, the Member should consult the our Customer Service Center before making any such additional Deductible, Copayment (Mail Order Pharmacy) or Co-insurance. A Member shall not be liable to a Participating Provider/Practitioner for any sums owed to the Provider/Practitioner by PIC.

D. Procedure for Reimbursement

If a charge is made to a Member for Covered Benefits, written proof of such charge must be furnished to PIC within 90 days from the date of service for Participating Providers/Practitioners and within one year from the date of service for non-Participating Providers/Practitioners in order for reimbursement to be made. Members relying on a non-Participating Provider/Practitioner to file on their behalf are responsible for ensuring claims have been submitted within one year from the date of services. Any such charge shall be paid only upon receipt of written proof satisfactory to PIC of the occurrence, character and extent of the event and services for which claim is made.

Failure to furnish such proofs shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such is furnished as soon as possible and in no event, except in the absence of legal capacity, later than one year.

If you need a claim form please contact our Customer Service Center at **(505) 923-6980** or toll-free at **1-800-923-6980**, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407**. Claim forms are also available on our website at www.phs.org. Please submit your completed claim form to:

Presbyterian Insurance Company, Inc.
Attn: Claims
P.O. Box 26267
Albuquerque, NM 87125-6267

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 the Benefits section 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. PIC may terminate a Member for any type of fraudulent activity. For further information regarding Fraud refer to the General Information section item L. (Fraud).

XI. EFFECT OF OTHER COVERAGE

Some Members may have medical Coverage through other health benefit plans. This Section explains how Presbyterian Insurance Company, Inc., Inc. (PIC) coordinates these benefits along with your PIC Coverage.

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 spire of rules a, b, c, d, or e, the plan that has not provision regarding coordination of benefits will pay first.

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 home owner's insurance policy. If such benefits have been provided by PIC, PIC shall have the right to recover any benefits provided from the Member or from the motor vehicle or homeowner's insurance to the extent they are available under the motor vehicle or homeowner's insurance policy.

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, PIC

a. may release, request, or obtain claim information from any individual or organization. In addition, any Member claiming benefits from PIC shall furnish PIC with any information which it may require; and

b. has the right, if overpayment is made by PIC 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 PIC's policies and procedures.

5. Members who are on COBRA continuation and are also Covered by another Group plan shall receive PIC benefits to the extent that PIC is secondary payer of all eligible charges, subject to the terms, conditions and limitation of this Agreement.

B. Medicare

Any Member enrolled on Medicare is not eligible for this plan. However, the Member can convert to a Presbyterian Senior Care Plan, provided they meet the eligibility requirements of the plan, upon eligibility for Medicare. It is the responsibility of the Member to notify PIC of eligibility or enrollment in Medicare. You may call Presbyterian Medicare Health Plan Consultant at **(505) 923-8458** or toll-free at **1-800-347-4766**. TTY users may call **1-866-593-7431.**

HSA Note: If you are eligible for Medicare, then you may not be eligible to contribute to a Health Savings Account. Please contact your HSA administrator or financial institution for further information.

C. Medicaid

Benefits payable by PIC 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 Title 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.

HSA Note: If you are enrolled in Medicaid, then you may not be eligible to contribute to a Health Savings Account. Please contact your HSA administrator or financial institution for further information.

D. 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, PIC 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 PIC for such benefits. This means that if PIC provides or pays benefits, a Member must repay PIC the amounts recovered for all such payments made by PIC 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, PIC'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 PIC such documents and papers as may be necessary to protect PIC's subrogation right. The Member also agrees to keep PIC advised of:

   a. any claims or lawsuits made against any person, firm or entity responsible for any injuries for which PIC 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 PIC is a violation of this Agreement. In the event a Member fails to cooperate with PIC or takes any action, through agents or otherwise, to interfere with the exercise of PIC's subrogation right, PIC 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 PIC, PIC 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 PIC receives appropriate documentation of such collection costs and legal expenses.

HSA Note: Generally, an individual is ineligible for a Health Savings Account if the individual, while covered under a qualified HDHP, is also covered under another health plan (whether as an individual, spouse, or Dependent) that is not a qualified HDHP. However, certain other kinds of health coverage may be maintained (by an individual) without losing eligibility for an HSA. Please contact your HSA administrator or financial institution for further information.

An individual does not fail to be eligible to contribute to an HSA merely because, in addition to an HDHP, the individual has coverage for any benefit provided by "permitted insurance". Permitted insurance is insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., automobile insurance), insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization.

Please contact your HSA administrator or financial institution for further information on eligibility requirements.

XII. 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 Presbyterian Insurance Company, Inc. Inc. (PIC) at **(505) 923-6980** or toll-free at **1-800-923-6980.** TTY users, call **1-877-298-7407** 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 **1-888-4ASK-PRC (1-888-427-5772).**

PIC has established written procedures for reviewing and resolving your Grievances and concerns. There are two different procedures, depending on the type of Grievance. Any person dissatisfied with a decision, action or inaction of PIC, including a termination of coverage, has the right to request an internal review. You may submit your request verbally or in writing.

Adverse Determination Grievance: If your Grievance concerns a decision by PIC 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 PIC concerning any other aspect of PIC's health benefits plan, other than the request for healthcare services, including, but not limited to, administrative practices of the Healthcare Insurer that affect the availability, delivery, or quality 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, PIC's Customer Service Center will assist you to complete the required forms. The managed health care bureau of insurance division is also available to assist you. Please be advised that PIC shall not take any retaliatory action against you for filing a Complaint.

If your grievance contains adverse determination issues and administrative grievance issues, PIC will initiate separate complaints for each decision.

When processing your Grievance, PIC will provide you with a detailed explanation of the grievance procedure. The detailed explanation will tell you how PIC reviews and resolves grievance, provide you with a toll-free telephone number, facsimile number, e-mail address, and mailing address of PIC's consumer assistance office.

You may request a copy and detailed written explanation of the Grievance procedures by calling PIC at (505) 923-6980 or toll-free at **1-800-923-6980.** TTY users, call **1-877298-7407**.

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

A. Initial Determinations

When you or your treating healthcare professional requests a healthcare service, PIC shall initially determine whether the requested healthcare service is a Covered benefit by your health plan. Before denying a health care service for lack of coverage, PIC will determine that there is no provision under which the requested health care service could be Covered. If PIC finds that the requested health care service is not Covered, PIC will not review for medical necessity. If PIC finds that the requested health care service is a Covered benefit, PIC will then determine if it is medically necessary. Before PIC denies a healthcare service because of lack of medical necessity, our Medical Director will give an opinion as to medical necessity by either consulting relevant specialists or applying uniform standards used by PIC.

The initial determination must be completed within 24 hours where circumstances require expedited review, and five working days for all other cases. Presbyterian may extend the review period for a maximum of ten (10) working days for pre-services cases and a maximum of twenty (20) working days for post-service cases if there is a demonstration of reasonable cause beyond control for the delay, the delay will not result in increased medical risk to you, and if a written progress report and explanation for the delay within the original five (5) working day review period is sent to you.

An expedited decision will be granted whenever:

1. the life or health of a Covered person would be jeopardized;
2. the Covered person's ability to regain maximum function would be jeopardized;
3. the provider reasonably requests an expedited decision; or
4. the medical exigencies of the case require an expedited decision.

If PIC's initial review results in the approval of the requested service, then PIC will notify you and your doctor of the approval by telephone or written correspondence within two (2) working days of the date the service was approved by PIC.

If PIC's initial review results in the denial, reduction or termination of the requested healthcare service, then PIC will notify you and your doctor of the determination by telephone no later than twenty-four (24) hours after making the initial decision. PIC will also notify you and your doctor of the initial decision in writing within one (1) working day of the telephone notice. The written notice will state:

1. if the decision is based on lack of medical necessity and explain why the service is not medically necessary
2. if the decision is based on lack of coverage, all benefit plan provisions and materials will be cited completely explaining why the requested service is not a Covered benefit.
3. how you may request an internal review with PIC
4. procedures and provide all the necessary forms you will need to request an internal review.

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

Presbyterian Insurance Company, Inc.
Grievance Department
2501 Buena Vista Drive SE
Albuquerque, NM 87106
(505) 923-5644 or toll-free at **1-800-923-6980**
FAX (505) 923-5124
E-mail: gappeals@phs.org

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

B. Adverse Determination Grievance Review Procedures

Once PIC receives your request for an internal review, we will date and time stamp your request and send you an acknowledgement letter within one (1) working day. PIC's acknowledgement letter will tell you the name, address, and direct telephone number of the individual handling your request.

PIC's internal Adverse Determination Appeal Review Procedures require an initial review by a PIC medical director then, if necessary, as second reviewed by a medical panel. If your request was initially denied because of lack of coverage, PIC's medical director will review your benefit plan booklet to determine if there is any provision under which the requested health care service could be Covered. If the initial request was based on lack of medical necessity, then our Medical Director will give an opinion as to medical necessity by either consulting relevant specialists or applying uniform standards used by PIC. If PIC's decision is to approve the requested service, PIC will notify you and your doctor by telephone and written correspondence within two (2) working days of the date the service was approved by PIC. Both reviews must be completed within 72 hours when the circumstances require expedited review; or within twenty (20) working days for all cases in which the request for review is made prior to the service requested; and forty (40) working days for all cases that involve post-service reviews. An expedited review is conducted when it is determined your life or health could be in jeopardy, or your ability to regain maximum function would be jeopardized. In an expedited review, all information will be transmitted between you and PIC by the most expeditious method available. If an expedited review is conducted during a hospital stay or course of treatment, the services will be continued without cost (except for applicable Copayment, Co-insurance and deductibles) to you until PIC makes a final decision and notifies you. PIC will not conduct an expedited review of an adverse determination made after health care services have been provided to you. Presbyterian will work with you if an extension is needed – ten (10) working days for pre-service cases and twenty (20) working days for post-service cases. The reasons for an extension include demonstrating a reasonable cause beyond control and demonstrating that the delay will not result in increased medical risk to you. PIC will send you a written progress report explaining the reason for the delay within thirty (30) days for pre-service or sixty (60) days for post-service. If PIC fails to comply with the deadline for completion of an internal review, the requested service may be approved unless you agree in writing to an extension.

If PIC's medical director decides to uphold the denial, reduction or termination of the requested healthcare service, then PIC 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 no longer wish to pursue the grievance, PIC will mail to you a written notification of PIC's decision and confirmation of your decision that you do not wish to pursue the matter further within three (3) working days of the medical director's decision. If PIC is unable to contact you by telephone within seventy-two (72) hours of making the decision to uphold, PIC will notify you by mail of the decision and will include a self-addressed stamped response form which asks whether you wish to pursue the grievance further. The form will include a box for checking "yes" and a box for checking "no". If you do not return the response form within ten (10) working days, PIC will again contact you by telephone. If you do not respond to our telephone inquires or return the response form, PIC will close the file including the documented efforts to contact you within twenty (20) working days. If the review is an expedited review, then PIC will select a medical panel to further review your request. PIC will not reasonably deny your request for a postponement of the internal panel review.

If you do not make an immediate decision to pursue the matter further or you have requested additional time to supply supporting documentation or information, the timeframe will be extended to include additional time.

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

- attend and participate in the internal panel review;
- present your case to the internal panel;
- submit any additional information before and at the internal panel review;
- ask questions of any Presbyterian representative including the internal panel;
- be assisted or represented by a person of your choice, including legal representation (at your expense);
- be advised if PIC will have legal representation at the hearing; and
- hire a specialist to participate in the internal panel hearing at your own expense, but the specialist may not participate in making the decision.

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

The internal review panel will review your benefit plan booklet if there is any provision under which the requested health care service could be Covered. The internal review panel will give an opinion as to medical necessity by either consulting relevant specialists or applying uniform standards used by PIC.

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

- pertinent medical records;
- your doctor's recommendation;
- your benefit plan booklet;
- all PIC decision letters;
- any uniform standards used by PIC;
- any reports received from any medical consultants retained by PIC; and
- all other evidence or documentation used in your review.

For an expedited internal review, all information will be provided to you by the most expeditious method available. If an expedited review is conducted during a hospital stay or course of treatment, PIC will continue the service (applicable co-payments and deductibles apply) until PIC makes a final decision. PIC will not conduct an expedited review of an adverse determination made after health care services have been provided to you.

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

- the names, titles, and credentials of the internal review panel members;
- a statement of the internal panel's understanding of the grievance and all pertinent facts;
- the rationale for the internal review panel's decision;
- every relevant provision of your health benefits booklet;
- reference uniform standards relevant to the decision;
- reference any other evidence or documentation used to make the decision;
- your right to request an external review by the Superintendent of Insurance.

External Review by the Superintendent of Insurance: If you are dissatisfied with the results of the review of an adverse determination by PIC, you may request an external review by the Superintendent by filing a written request within twenty (20) working days from the date you receive PIC's decision. You may also file any other supporting documents or information to the superintendent for review. If you wish to supply supporting documentation or information subsequent to the filing for an external review, the time frames for external review shall be extended up to 90 days from the receipt of the complaint by the Superintendent of Insurance, or until you submit all supporting documents, whichever occurs first. You may request the Superintendent extend your request if good cause is shown. You may file your request by:

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;
3. Fax to the Superintendent of Insurance, Attention Managed Health Care Bureau—External Review Request, at **(505) 827-4734**;
4. Online by completing the NM PRC, Division of Insurance Complaint Form available at http://www.nmprc.state.nm.us or
5. You or your doctor may request an expedited review by calling the managed health care bureau at (505) 827-3928 or 1-877-673-1732.

You will need to provide a copy of the PIC decision, a fully executed release form authorizing the Superintendent to obtain any necessary medical records from PIC or other healthcare service Provider/Practitioner; and any other supporting documentation. If the grievance involves an experimental or investigational treatment adverse determination, provide a copy of your provider's certification and recommendation. You may contact the Managed Health Care Bureau to assist you in this process. The Superintendent may require you to exhaust any internal PIC grievance procedures before accepting a grievance for external review.

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

- your summary of benefits;
- your complete health benefits booklet;
- all pertinent medical records, internal review decisions and rationales, consulting reports, and any documents and information submitted by you and PIC;
- any uniform standards used by PIC; and
- all or evidence or documentation used in your internal review.

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

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

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

- you have provided the necessary documents;
- you are or were a Covered person under PIC at the time the service was requested or provided;
- you have exhausted all PIC's internal review procedures; and
- the requested service is a Covered benefit under your benefit plan booklet.

If your external review request pertains to an experimental or investigational treatment, the insurance division staff will also consider whether the requested service is a Covered benefit, is not listed as an excluded benefit under your plan and whether your doctor has certified that standard health care services have not been effective or are not medically appropriate for you. The insurance division staff will also consider whether there is no standard health care service Covered by PIC that is as beneficial as, or more beneficial than the requested service.

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

The Superintendent may designate a hearing officer who will be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense. The Superintendent may also designate two (2) independent co-hearing officers who will be licensed Health Care Professionals. At least one of them will practice in a specialty that would typically manage the case related to your grievance. Each hearing officer will disclose any potential conflicts of interest to the Superintendent. Any potential conflicts of interest can include personal or professional relationships to either you or PIC. The Superintendent will determine reasonable compensation for the appointed hearing officers and will annually publish a schedule of hearing officer's compensation in a bulletin. The Superintendent or attorney hearing officer may require additional information, may exclude any irrelevant evidence, may adjourn or proceed with the hearing if you or PIC fails to attend the hearing. Staff may attend the hearing, ask question, and request evidence from the parties, but will not be present during deliberations between the superintendent, his designated hearing officer, and any co-hearing officers. All testimony at the hearing will be taken under oath. The Superintendent or hearing officers may call and examine you, PIC designees, and other witnesses. The hearing will be recorded and you and PIC have the right to attend the

hearing designate a person to attend on your behalf, be assisted or represented by an attorney and call, examine and cross-examine witnesses. You and PIC will each enter into record that the hearing officers will be released from civil liability for all communications, finding, opinions, and conclusions made during the external review process. At the close of the external hearing the hearing officers will review and consider your entire record and submit their decision to the Superintendent who will then render a decision in your case to include any further grievance rights. If the decision requires action on the part of PIC, the order will state the timeframe for compliance. Once your external review is complete, the hearing officers will complete a compensation form indicating the amount of time spent participating in your external review. The completed forms will be submitted to the Superintendent and will be forwarded to PIC. PIC will compensate the hearing officers for time served within thirty (30) days of receipt.

The Superintendent's order will be binding to both you and PIC and will state that both you and PIC have the right to judicial review in accordance with NMSA 1978 Section 59A-4-20 as state and federal law may provide other remedies. You or PIC cannot file a subsequent request for external review of the same adverse determination that was the subject of the Superintendent's order.

C. Administrative Grievance Procedures

If you are dissatisfied with a decision, action or inaction of PIC regarding a matter that does not involve the denial, reduction or termination of a requested healthcare service, then you have the right to request, orally or in writing, that PIC internally review the matter. Once PIC receives your request for an internal review, we will date and time stamp your request and send you an acknowledgement letter within three (3) working days. PIC's acknowledgement letter will tell you the name, address, and direct telephone number of the individual handling your request. Your request will be conducted by a PIC who will allow you to present any information related to your case and who will take corrective action if necessary. PIC will review the Grievance and provide you with a written decision within fifteen (15) working days from receipt of the Grievance. PIC will notify you if an extension is necessary. An extension may be granted when there is a delay in obtaining the documents or records necessary to appropriately review your grievance. PIC will notify you in writing of the reasons for the extension within the original review period and the expected date of resolution. Your written decision will include:

- the name, title, and qualifications of the person conduction the initial review;
- a statement of the review's understanding of the grievance and all pertinent facts;
- the rationale for the decision;
- every relevant provision of your health benefits booklet;
- reference uniform standards relevant to the decision;
- reference any other evidence or documentation used to make the decision; and
- your right to request a reconsideration within twenty (20) working days including all necessary forms.

If you are dissatisfied with this decision, you may file a written request for reconsideration by PIC. PIC will appoint a reconsideration committee, consisting of one or more employees of the plan who were not involved in the initial decision, to review the Grievance and will schedule a hearing. PIC will notify you of the date, time and location of the hearing and your rights in this process within ten (10) working days after your hearing request is received. No fewer than three (3) working days prior to your hearing, PIC will send you all the documents and information the committee will be reviewing. The reconsideration committee hearing will be held within fifteen (15) working days after your hearing request is received. PIC will mail you a written decision within seven (7) working days after the hearing.

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

- attend and participate in the reconsideration committee review
- present your case to the internal panel
- submit any additional information before and at the reconsideration committee review
- ask questions of any PIC representative including the internal panel
- be advised if PIC will have legal representation at the hearing
- be assisted or represented at your expense by a person of your choice

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

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

External Review by the Superintendent of Insurance: If you are dissatisfied with the results of the review by PIC's reconsideration committee, you may request an external review by the Superintendent by filing a written request within twenty (20) working days from the date you receive PIC's decision. You may also file any other supporting documents of information to the Superintendent for review. If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the time frames for external review shall be extended up to 90 days from receipt of the complaint form by the Superintendent of Insurance, or until you submit all supporting documents, whichever comes first. You may file your request for external review on the forms provided by PIC 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;** or
4. Online by completing the NM PRC, Division of Insurance Complaint Form available at http://www.nmprc.state.nm.us.

The Superintendent may require you to exhaust any internal PIC grievance procedures before accepting a grievance for external review.

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

- your summary of benefits;
- your complete health benefits booklet;
- all pertinent medical records, internal review decisions and rationales, consulting reports, and any documents and information submitted by you and PIC;
- any uniform standards used by PIC; and
- all or evidence or documentation used in your internal review.

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

D. Retaliatory Action

In accordance with the Patient Protection Act, and the New Mexico Administrative Code's Grievance Procedures Rule (NMAC 13.10.17.9), PIC cannot take retaliatory action against you for filing a Grievance under this health benefits plan.

E. Confidentiality of a Covered Person

In accordance with the Grievance Procedure Rule (NMAC 13.10.17.11A), health care insurers, the superintendent, independent co-hearing officers, and all others who acquire Access to identifiable medical records and information of Covered persons when reviewing Grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

XIII. RECORDS

Your medical records are important documents needed in order to administer your benefit plan. This Section explains how Presbyterian Insurance Company, Inc. (PIC) ensures the confidentiality of those records and how these records are used to administer your benefit plan.

A. Creation of Non-Medical Records

PIC shall keep Member records related to identification information which does not specifically relate to the members medical diagnosis or treatment. The individual Member shall forward information periodically as may be required by PIC in connection with the administration of this Agreement.

B. Accuracy of Information

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

C. Consent for Use and Disclosure of Medical Records

PIC 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 PIC. 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 PIC 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. PIC will comply with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations

D. Professional Review

PIC 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 PHI/Medical Records

Each Member will receive a Notice of Privacy Practices that PIC 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 PHI?

PHI is any health information about you that PIC 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 PHI. Medical records and claims are two examples of PHI.

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

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 PIC is not required to agree to a requested restriction;

b. receive confidential communications of PHI from PIC;

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 PIC 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;

b. Information gathered in reasonable expectation of, or for use in, a civil, criminal, or administrative action or proceeding; or

c. PHI maintained by Presbyterian Insurance Company, Inc. 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 Insurance Company, Inc.
Attn: Director, Customer Service Center
P.O. Box 26267
Albuquerque, NM 87125-7489

PIC will act on your request for access to PHI no later than 30 days after receipt of the request. If PIC 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 PIC will complete its action on your request.

3. **Routine Uses and Disclosures of PHI**

PIC routinely 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; and

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;

j. responding to Member' requests for information, products or services.

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

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

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 PIC 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 PIC, or you refuse to sign such consent for disclosure to PIC, Presbyterian Insurance Company, Inc. 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 PIC 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 PIC 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 PIC Plan. This consent does not permit a use or disclosure of PHI when an authorization is required by law.

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

We require all Participating Providers/Practitioners and facilities to maintain confidential patient information in accordance with federal and state laws including, HIV/AIDS status, mental health, sexually transmitted diseases or alcohol/drug abuse. State and federal law prohibits further disclosure of HIV/AIDS, other sexually transmitted 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 Customer Service Center at **(505) 923-6980** or toll-free at **1-800-923-6980**, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407**. 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**

PIC recognizes your right to request amendment of PHI or a record containing PHI for as long as the PHI is maintained in our records. Presbyterian Customer Service Center will accept written requests to amend PHI. PIC must approve or deny your request to amend the disputed PHI no later than 60 days after receipt of the request. If PIC 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 PIC 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 our Customer Service Center. With some exceptions, as described in the Notice of Privacy Practices issued by PIC the accounting will show when PIC 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. PIC'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.

PIC is not required by law to agree to any requested restriction. If PIC does agree to honor a requested restriction, PIC will not violate such restriction, except as permitted by law. PIC 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 PIC to know about the illnesses of our Members to help improve the quality of care our Health Care Practitioners provide to you. PIC 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 PIC**

To ensure internal protection of oral, written, and electronic PHI across PIC, 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 PIC that involves health information will be held responsible for the proper handling of PIC'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 PIC's workforce is grounds for disciplinary action, up to and including immediate dismissal.

11. **Web Site Internet Information**

PIC 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.

PIC 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**

PIC 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). PIC 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 our Customer Service Center at **(505) 923-6980**, toll-free **1-800-923-6980**, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call **1-877-298-7407.**

XIV. TERMINATION

This Section explains what conditions can cancel your Presbyterian Insurance Company, Inc. Coverage (PIC).

A. This Agreement shall be canceled and shall terminate in the event that any of the following conditions occurs:

1. Non-Payment: In the event any Contract charge, including a Prepayment and any applicable finance charge or charges, is not paid to PIC when due, a notice of cancellation shall be mailed by PIC to the Subscriber by first-class mail at his/her current address a legible copy of such notice. Receipt by PIC 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 item. If payment of such charge is not received within this 15-day period, PIC may, at its option, either:

   a. require that a new Application for Coverage be submitted, notifying the Subscriber 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 Subscriber within 20 business days after receipt of any Prepayment for Coverage for periods after the effective date of cancellation.

   Cancellation and termination of this *Subscriber Agreement* under this item shall become effective as of the last date of payment. PIC shall be entitled to recover from the Subscriber any and all payments after the last date of the period for which Prepayment was received.

2. Voluntary Termination. Coverage may be terminated by the Subscriber on at least 30 days prior written notice. Such termination shall only be effective as of the last day of the month, following the 30 day period, based on PIC's receipt of termination request.

3. **Ten-day review of Contract:** A Member is allowed a ten-day period, from the effective date of the Contract, to examine and return the Contract and have the premium refunded. If services were received during the ten-day period, and the Member returns the Contract to receive a refund of the premium paid, the Member must pay for such services.

B. This Agreement Shall Terminate Automatically for a Member:

1. On the date specified by PIC, in the case of a Member who refuses to pay any required Copayments and/or Co-insurance for health services rendered, provided that written notice is sent to the Subscriber at least 30 days in advance of such termination. PIC will not cancel an Enrollee's *coverage* for non-payment of Copayments and/or Co-insurance during any period in which a Member is hospitalized and receiving treatment for a life-threatening condition. In addition, PIC will not cancel a Member's *coverage* for refusal to follow any prescribed course of treatment.

2. On the date specified by PIC 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, PIC 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 PIC for all such payments made by PIC 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 in the PIC 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 in the Service Area.

6. At the end of the month, 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 PIC Identification Card by any other person, PIC 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 Practitioners, after reasonable effort, are unable to establish and maintain a satisfactory Provider/Practitioner/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 a material failure to abide by PIC's rules, and/or policies and procedures; provided that written notice is sent to the Subscriber at least 30 days in advance of such termination.

10. PIC may terminate the Contract with a Member at the end of any month for Good Cause by giving written notice of termination 30 days prior to the effective date of termination. Upon termination of this *Subscriber Agreement*, all fees which are accrued and unpaid at the time of termination shall be due to PIC.

11. No statement (except a fraudulent statement, as identified in the General Information section item L. of this Agreement) made by a Member in any Application for Coverage that is more than two years old can void this Coverage or be used to deny a claim for loss incurred under this policy unless the Application or a true copy of it is incorporated in or attached to the Contract.

C. PIC 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. PIC 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 PIC terminates or suspends any contract with a Participating Provider/Practitioner, PIC will make best efforts to notify, in writing, each affected Member who is a current patient within 30 days. PIC shall assist each affected Member in locating and transferring a Member to another similarly qualified Participating Provider/Practitioner, if available, or continued In-network benefits. You may continue to receive care from this Non-participating Provider/Practitioner, however services will be paid at the Out-of-network benefit level.

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.

XV. PREMIUM PAYMENT

This Section explains how premium payments are to be made to Presbyterian Insurance Company, Inc.

A. Prepayments

Prepayments, as identified in the approval letter or any notice of Prepayment change, are payable in advance by the Subscriber or the financially responsible party to PIC at its offices in Albuquerque, New Mexico. The first Prepayment is due and payable at the time of Application. Subsequent Prepayments will be drafted each month from the Subscriber's or financially responsible party's bank account as specified in the Subscriber's approval letter.

If the transaction is returned by the Subscriber's or financially responsible party's financial institution for insufficient funds, account closed, authorization revoked, or any other reason caused by an act of the Subscriber or financially responsible party, payment of the amount billed plus a finance charge must be received by PIC within 31 days from the date the Prepayment was due. Failure to remit payment in full (including any applicable finance charge) within this timeframe will result in termination effective as of the last day of the month for which payment has been received.

B. Changes in Prepayments

PIC reserves the right to change the Prepayment amount for the Covered Benefits provided under this Agreement as follows:

1. at the beginning of any month in which PIC has given the Subscriber 60 days prior written notice of change in Prepayment; or

2. at the beginning of the month in which the Subscriber/Member changes Coverage classifications such as:

   a. new age category or geographic location; or

   b. addition of Dependent(s);

3. on any date that the provisions of the Agreement are amended which result in a premium change. Written notice of such change in Prepayment amount shall be given by PIC to the Subscriber at least 60 days prior to the effective date of the Prepayment change.

XVI. GENERAL PROVISIONS

This Section explains several miscellaneous topics not covered in other Sections of this Subscriber Agreement.

A. Notice

Any notice required or permitted to be given by Presbyterian Insurance Company, Inc. (PIC) in this Agreement shall be given appropriately if in writing and deposited in the United States mail with postage prepaid and addressed to the, Subscriber at the address of record on file at the principal office of PIC. The Subscriber 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 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 medical assessment form completed upon enrollment, the Individual Application Form of the Subscriber Covered hereunder and the issued PIC 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 PIC, has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making payment, or to bind PIC 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 signed by one of the aforesaid officers.

F. Amendments

This Agreement shall be subject to amendment, modification, or termination in accordance with their provisions or by mutual agreement in writing between PIC and the Subscriber. 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.

G. Reinstatements

PIC 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.

H. Identification Cards

Identification Cards issued by PIC to Members pursuant are for identification purposes only. Possession of a PIC 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 PIC.

I. Policies and Procedures

PIC may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

J. Assignment

All rights of a Member to receive benefits and services are personal, and may not be assigned.

K. 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 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, PIC will provide 24-hour healthcare Coverage to those employees, subject to the eligibility requirements for Coverage with PIC. In addition to meeting all of PIC's eligibility requirements, documentation indicating that the aforementioned criteria have been met will be required in order for Coverage with PIC to become effective.

L. 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.

M. Right to Examine

Presbyterian Insurance Company, Inc., at it's own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

N. Availability of Provider Services

PIC does not guarantee that a certain type of service, Hospital, facility, Provider/Practitioner, or other provider/Practitioner will be available in the PIC network.

O. Provider/Practitioner Liability

Providers and Practitioners, whether Participating or not, have sole control over the diagnosis, treatment, care, or other service provided to a Member or by any facility, and therefore PIC is and will not be liable for any loss or injury caused by any health care Provider/Practitioner by reason of such Provider or Practitioner's negligence or otherwise.

P. Misstatements

After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the Application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in this *Subscriber Agreement*) commencing after the expirations of such two-year period. All statements in the absence of fraud, made by an applicant or applicants shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce the benefits there under unless contained in a written Application for such insurance.

Q. HSA Note: Health Savings Account Information

This *Subscriber Agreement* describes only the medical/surgical plan benefits that are available to Members under this plan. Please contact the Health Savings Account (HSA) administrator or financial institution you chose to be the administrator of your HSA about the details of that account, your banking arrangement(s), the amount of money you add to that account, administration fees, and the rules regarding the use of the account to pay for medical expenses not paid under this plan.

XVII. GLOSSARY OF TERMS

This Section defines some of the terms used in this 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 *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 OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered services received in a Calendar Year 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 PIC Coverage.

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.

BENEFIT CERTIFICATION means a decision by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health car services is therefore approved.

BENEFIT CERTIFIED means Benefit Certification was obtained (when required) prior to obtaining Covered Benefits.

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.

CERTIFICATE OF CREDITABLE COVERAGE means a Certificate given to a Member when his/her enrollment from PIC terminates and which states the period of time that the Member was Covered by PIC under a benefit plan for healthcare services. When terminating from this Individual plan PIC will be responsible to prepare and deliver the Certificate, in compliance with all applicable requirements of state and federal law, to the Member.

CERTIFIED NURSE PRACTITIONER means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a Certified nurse practitioner and whose name and pertinent information is entered on the list of Certified nurse practitioners maintained by the board of nursing.

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).

CO-INSURANCE means the percentage amount of Covered charges required to be paid by a Member, after the Deductible has been met, directly to the Provider/Practitioner in connection with healthcare services.

COMPLAINT means the first time PIC 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 *Subscriber Agreement*. This *Subscriber Agreement* including the *Schedule of Benefits*, any supplements or riders, the medical questionnaire, and the issued Identification Card, constitute the entire Contract.

COPAYMENT means the amount required to be paid by a Member directly to the Provider/Practitioner in connection with healthcare services.

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 by PIC. (This includes, but is not limited to, Medical and Pharmacy Benefits.)

DENTAL means non-medical dental benefits underwritten and administered by Delta Dental Plan of New Mexico, Inc. as depicted in Exhibit C.

DEPENDENT means any member of a Subscriber's family who meets the requirements of the Eligibility, Enrollment and Effective Dates section item A.(2). of this Agreement, is enrolled hereunder, and for whom the Prepayment has been actually received by PIC.

DIAGNOSTIC SERVICE means procedures ordered by a Provider/Practitioner or Provider/Practitioner to determine a definite condition or disease.

DURABLE MEDICAL EQUIPMENT means equipment prescribed by a Provider/Practitioner 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.

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/prudent 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 PIC.

EVIDENCE-BASED MEDICAL LITERATURE means only published reports and articles in authoritative, peer-reviewed medical and scientific literature.

EXPERIMENTAL OR INVESTIGATIONAL refer to the Exclusions section item AA. of this 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 PROGRAM (FIT) means an early intervention services program provided through the Family, Infant, and Toddler Program to eligible children and their families in accordance with requirements under Senate Bill 589 as defined in Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.

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 PKU, 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.

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.

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

HOME HEALTHCARE SERVICES means health services provided to a Member confined to the home due to physical illness. 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 PIC and when prescribed by the Member's Provider/Practitioner.

HOSPICE means a duly licensed facility or program, which has entered into an agreement with PIC to provide healthcare services to Members who are diagnosed as terminally ill.

HOSPITAL means an acute care general Hospital, which:

1. 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 Provider/Practitioners; and
2. is not, other than incidentally, a place for rest, a place for the aged, or a nursing home; and
3. is duly licensed to operate as an acute care general Hospital under applicable state or local law.

HUMAN PAPILLOMAVIRUS SCREENING means a test approved by the Federal Food and Drug Administration for detection of the human papillomavirus.

IDENTIFICATION CARD or ID CARD means that card issued to a Member upon approval of an Application by PIC.

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 the Exclusions the of this Agreement.

LIFETIME MAXIMUM BENEFIT means the maximum dollar amount PIC will pay for a particular benefit during the lifetime of a Member under this *Subscriber Agreement*.

LONG-TERM THERAPY OR REHABILITATION SERVICES. Therapies are considered Long-term if the Member's Provider/Practitioner, in consultation with PIC, 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.

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

MANAGED HEALTH CARE PLAN means a health benefit plan offered by PIC as a health care insurer that provides for the delivery of Comprehensive Basic Health Care services and medically necessary services to individuals enrolled in the plan through its own employed health care providers or by contracting with selected or participating health care providers. This Plan is considered to be a Managed Health Care Plan.

MATERNITY means any condition that is pregnancy related.

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

MEDICAL NECESSITY OR MEDICALLY NECESSARY means appropriate or necessary services as determined by a Provider/Practitioner in consultation with PIC, 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 PIC 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.

MEDICAL DRUGS (Medications obtained through the medical benefit) means medications administered in the medical office or facility that require a healthcare professional to administer. These medications include, but are not limited to injectable, infused, oral or inhaled drugs. They may involve unique distribution and may be provided by a specialty pharmacy vendor. Medical Drugs are office administered meaning they are incident to a provider/practitioner service that requires a healthcare provider to administer. Office administered applies to all outpatient settings including, but not limited to Provider/Practitioner's offices, emergency rooms, urgent care facilities and outpatient surgery facilities. Some Medical Drugs will require Benefit Certification before they can be obtained. For a complete list of Medical Drugs to determine which require Benefit Certification please see the Presbyterian Pharmacy website at www.phs.org. Your can call the Presbyterian Customer Service Center at **(505) 923-6980**, toll free **1-800-923-6980.** TTY users may call **(505) 923-5699** or toll-free **(877) 298-7407**.

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 *Subscriber Agreement*.

NON-PARTICIPATING PROVIDER/PRACTITIONER means a healthcare Provider/ Practitioner, including medical facilities, who has not entered into an agreement with PIC to provide healthcare services to PIC 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 PIC must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status. Medical criteria will also be considered. Observation for greater than 24 hours will require Benefit Certification.

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

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

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

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

OUT-OF-NETWORK SERVICES 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.

PARTICIPATING PHARMACY means any duly licensed pharmacy which has entered into an agreement with PIC to dispense prescribed drugs to PIC Members.

PARTICIPATING PROVIDER/PRACTITIONER 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 PIC to provide healthcare services to PIC 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 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'S ASSISTANT means a skilled person who is a graduate of a Physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Physician assistants, and who is licensed in the state of New Mexico to practice medicine under the supervision of a licensed Physician.

PROVIDER/PRACTITIONER means any duly licensed Practitioner of the healing arts acting within the scope of his/her license.

PIC means Presbyterian Insurance Company, Inc., a corporation organized under the laws of the State of New Mexico.

PPACA means Patient Protection and Affordable Care Act.

PPO means Preferred Provider Organization.

PRE-EXISTING CONDITION means a physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by a Member within the six-month period before the Member's effective date on this plan. The Pre-existing Condition limitation does not apply to children under age 19; a newborn child if enrolled in the plan within 31 days of birth; or an adopted child if enrolled in the plan within 31 days or placement. **Pregnancy and pregnancy-related diagnoses are not Covered**.

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

PREFERRED LIST means a list of drugs approved for Coverage under this *Subscriber Agreement* and will indicate at which tier level a drug is Covered. PIC'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 our Customer Service Center at **(505) 923-6980** or toll-free at **1-800-356-6980**, Monday through Friday from 7:00 a.m. to 6:00 p.m**.** TTY users may call **1-877-298-7407** or visit our website at www.phs.org.

PREPAYMENT means the monthly amount of money charged by PIC and payable in advance for benefits provided under this *Subscriber Agreement*.

PRESCRIPTION DRUGS/MEDICATIONS means those drugs that, by federal law, require a Provider/Practitioner'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 PIC's Service Area for medical, surgical, Hospital and related healthcare services.

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 PIC Members.

PULMONARY REHABILITATION means a program of therapy designed to improve lung functions.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN means a plan that does not provide/pay benefits until the respective Deductible for that year has been satisfied. The Federal Government has established minimum Deductibles and maximum out-of-pocket limits for a plan to be considered qualified and thus, satisfy one of the requirements for members wishing to contribute to a Health Savings Account (HSA). Please contact your HSA administrator or financial institution for further information on eligibility for enrollment in or contribution towards an HSA.

REASONABLE CHARGE or REASONABLE AND CUSTOMARY CHARGE means the amount determined to be payable by PIC for Covered services rendered to Members by Non-participating Providers/Practitioners, based upon the following criteria:

1. fees that a professional Provider/Practitioner usually charges for a given service;
2. 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
3. fees which are usual and customary or which could not be considered excessive in a particular case because of unusual circumstances.

REASONABLE/PRUDENT LAYPERSON means a person who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek emergency care. A reasonable/prudent layperson is considered to have acted "reasonably" if someone else in their same situation would also have believed that emergency care was necessary. Acting "reasonably" could include deciding that severe pain and other symptoms require emergency care. In determining whether the Member acted as a “reasonable/prudent layperson” as described under *Emergency Health Services* under the *Benefits* section, PIC 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 PIC’s established procedures for obtaining Emergency Health Services.

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.

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

SCREENING MAMMOGRAPHY means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic 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.

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 PIC is authorized to provide services as a Preferred Provider Organization. The Service Area is depicted on Exhibit A. The area may be changed by PIC by written notice to the Member.

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 that is licensed under state law to provide skilled care nursing services.

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 Provider/Practitioner and prescribed by a Provider/Practitioner;
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 to 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 (Tier 4 medications obtained through the Pharmacy benefit): means high cost (greater than $600 per 30 days supply) injectable, infused, oral or inhaled drugs that generally require complex care and supervision. These medications involve unique distribution and are usually provided by a specialty pharmacy vendor. Specialty Pharmaceuticals are used to treat serious chronic, often rare conditions such as: Hepatitis, Multiple Sclerosis, Rheumatoid Arthritis, Growth Disorders, Hemophelia, Immune Disorders, Osteoporosis, etc. Specialty Pharmaceuticals are self-administered meaning they are administered by the patient or to the patient by a family member or a care-giver. Some Specialty Pharmaceuticals will require Benefit Certification before they can be obtained. For a complete list of Specialty Pharmaceuticals and to determine which require Benefit Certification, please see the Presbyterian Pharmacy website at www.phs.org. Your can call the Presbyterian Customer Service Center at **(505) 923-6980**, toll free **1-800-923-6980.** TTY users may call **(505) 923-5699** or toll-free **(877) 298-7407**.

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

SUBSCRIBER means the person in whose name the Contract is issued.

SUBSCRIBER AGREEMENT means the booklet which describes the benefits for which the Subscriber and his/her eligible Dependents (if any) are eligible for under the terms of the Contract.

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 PIC for a Covered service and for Non-participating Providers/Practitioners, the Total Allowable Charges may not exceed the Reasonable and Customary Charge as determined by PIC for a service.

URGENT CARE means Medically Necessary healthcare services provided in emergencies or after a Provider/Practitioner'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.

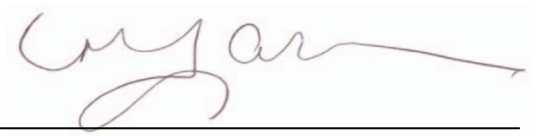
WELL CHILD CARE means routine pediatric care and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

WOMEN'S HEALTHCARE PROVIDER/PRACTITIONER means any Provider/Practitioner who specializes in women's health and is recognized as a Women's Healthcare Provider/Practitioner by PIC.

This *Subscriber Agreement* is issued to the Subscriber named in an Application received and accepted by Presbyterian Insurance Company, Inc., a New Mexico corporation. The terms and conditions appearing herein and any applicable amendments are part of this *Subscriber Agreement*.

IN WITNESS THEREOF, Presbyterian Insurance Company, Inc., has caused this *Subscriber Agreement* to be executed by a duly authorized agent.

PRESBYTERIAN INSURANCE COMPANY, INC.

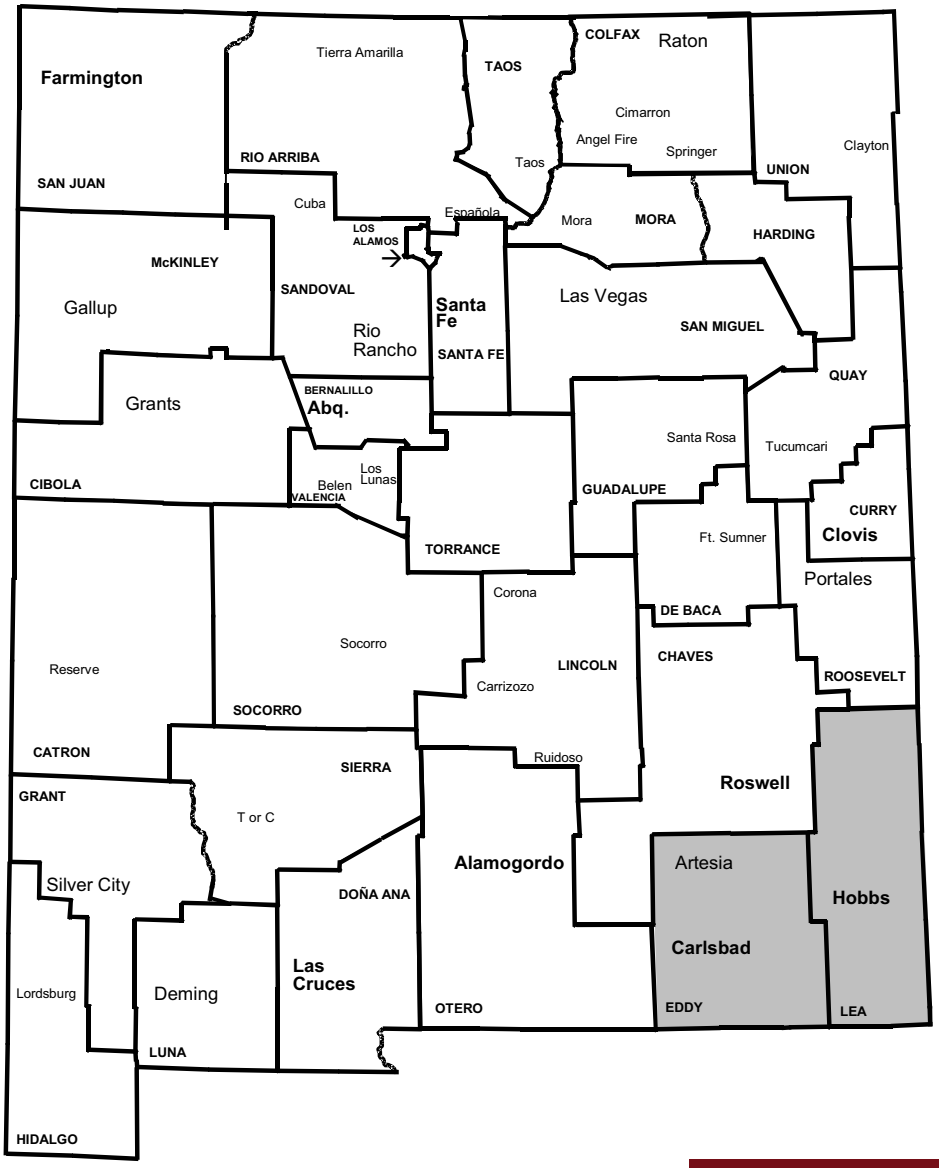


Lisa Farrell
Treasurer
Presbyterian Insurance Company, Inc.

EXHIBIT A

PPO Service Area Map

PRESBYTERIAN Insurance Company



New Mexico

Legend

Service Area
Not included in Service Area

Eff. 04/01/11

DELTA DENTAL

Delta Dental Online Resources

Presbyterian Individual Plan Members — Access a Provider Directory and Get a Personalized Delta Dental ID Card Today!

Featured Subscriber Information Available in the Subscriber Section

Go to Subscriber Materials, then sign in with your group number. View and print coverage documents:

- Summary of Benefits
- Network Information Page
- Provider Directory

Consumer Toolkit

Select the Consumer Toolkit link, sign in and:

- Verify eligibility of subscriber and dependents
- Confirm status of deductibles and plan maximums
- Review how a specific claim was processed
- Print a personalized subscriber ID card

If you do not have access to the Internet, you may call Delta Dental to request a Provider Directory and Reference Card.

Reference Cards are generic, blank cards that provide information for submitting claims to Delta Dental of New Mexico. ID cards or Reference Cards are not necessary to receive services from a Delta Dental dentist in New Mexico.

Because there are many Delta Dental offices around the country, it is helpful to show out-of-state providers an ID or Reference card to assure that claims are not delayed by being mailed to the incorrect address.

Telephone: (505) 883-4777
Toll Free: (800)-999-0963
Fax: (505) 883-7444

Benefit Services: (505) 855-7111
Toll Free: (877) 395-9420

All claims and customer service provided locally.

No frustrating phone "menu of options" from which to choose.

Talk to a local representative within 45 seconds of calling!

Great service is our way of saying "Thank you for your enrollment."

www.deltadentalnm.com / Subscriber Section

Welcome! Thank you for selecting Comprehensive Dental Plan benefits, which are fully insured by Delta Dental of New Mexico. The information on the following pages is provided to assist you in receiving care and benefits under your dental plan. Because it is a Point of Service plan, you may select – at the time a service is needed – a participating dentist from either of two Delta Dental provider networks.

Because the cost of dental services is less when a Delta Dental PPO℠ dentist is selected, patient out-of-pocket costs are reduced when a Delta Dental PPO dentist is selected for any type of service. Delta Dental Premier dentists are available when specialty care is needed and because some individuals may prefer to receive care from a dentist who only participates in that network. Delta Dental PPO and Delta Dental Premier® are both national networks, with providers in every state.

Updated provider directories are always available at deltadentalNM.com under the Dentist Directories link in the Subscriber Section. People who would prefer to search by specialists, zip code, provider name or general area may click in the Searching for a Dentist? box on the Home Page, select either Delta Dental PPO or Delta Dental Premier and enter the search criteria. Whenever possible, select Delta Dental PPO for the lowest possible out-of-pocket costs. This search tool can also be used to locate a dentist in another state.

As an optional service, patients may request a Predetermination of Benefits from the dental office before receiving services. The dentist submits a treatment plan, which can then be evaluated to determine, in advance, what services are covered, how much Delta Dental will pay, and what the patient's financial obligation will be. There is no cost for this service. Request a Predetermination of Benefits whenever a dentist recommends more expensive care. Predeterminations are mailed from Delta Dental both to the dental office and to the subscriber's home address. Predetermination is subject to eligibility and plan provisions at the time services are received, and it is not a guarantee of benefits.

Good oral health is an important part of good general health. Delta Dental plans are designed to promote regular dental visits. Take advantage of your benefits by calling a Delta Dental dentist today for an appointment.

Delta Dental Benefit Service Department
(505) 855-7111
or, when calling from outside the Albuquerque area,
toll free (877) 395-9420

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I. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

A. Who is Eligible?

Individuals who are enrolled in the Presbyterian Individual Medical Plan offered by Presbyterian Insurance Company, Inc. are eligible for this plan.

B. Enrollment

Eligible individuals must elect and enroll in Comprehensive Dental Plan benefits as of the date of their enrollment in Presbyterian Individual Medical Plan or on any subsequent Presbyterian Individual Medical Plan contract renewal date.

C. Effective Dates

The effective date for Comprehensive Dental Plan benefits is the same as the original Presbyterian Individual Medical Plan effective date if Comprehensive Dental Plan benefits were elected at that time.

Otherwise, Comprehensive Dental Plan benefits are effective on the Presbyterian Individual Medical Plan contract renewal date when Comprehensive Dental Plan benefits were elected.

Newly eligible dependents are automatically enrolled for dental benefits as of the date of their enrollment in Presbyterian Individual Medical Plan.

II. HOW THE PLAN WORKS

A. Delta Dental Provider Networks Information

The Delta Dental PPO network Point of Service plan is designed to offer subscribers the greatest amount of savings in the cost of dental care and the ability to choose, at the time services are received. Services received from either a Delta Dental PPO or Delta Dental Premier dentist are considered "In-Network".

1. How Benefit Payment Is Based On The Dentist Selected

A patient's share of the cost for any covered service depends on whether the dentist participates in Delta Dental PPO or the Delta Dental Premier network.

Delta Dental PPO dentists have agreed to Delta Dental PPO Maximum Approved Fees.

- Because lower Maximum Approved Fees result in lower charges for dental services, subscriber savings are maximized when a Delta Dental PPO dentist is selected.
- Although the Delta Dental PPO network may not include specialty dentists in every category in every area, most services are available in-network. Specialty categories include: oral surgery, endodontics, orthodontics, pedodontics, periodontics and prosthodontics. For maximum savings, refer to the Delta Dental PPO network provider directory and select a participating dentist, including specialists, whenever possible.

Delta Dental Premier dentists have agreed to Delta Dental Premier Maximum Approved Fees.

- With approximately three out of four dentists participating nationally, Delta Dental Premier is the country's most comprehensive panel of providers.

- As an offset to this broader selection, charges for services, and the corresponding dollar amount of patient co-pays, will typically be higher than when services are received from a Delta Dental PPO network dentist. Refer to the Summary of Benefits for the difference in benefit levels based on the network selected.

Non-participating dentists are dentists who do not participate in any Delta Dental dentist network.

- Benefits apply for covered services received from a non-participating dentist, but subscriber out-of-pocket costs are typically higher.
- Any payment made by Delta Dental will be based on the dentist's submitted charge, subject to the Maximum Approved Fees applicable to non-participating dentists. Maximum Approved Fees may be greatly reduced for non-participating providers. Non-participating dentists may bill a Delta Dental subscriber for amounts over and above the applicable Delta Dental Maximum Approved Fee, frequently resulting in higher out-of-pocket costs for covered services.
- Subscribers are responsible for payment of the deductible, when applicable, co-payments, fees for services for which no benefit is applicable plus any difference between the payment made by Delta Dental and the non-participating dentist's actual charge.
- Any payment made by Delta Dental for services received from a non-participating provider may be paid to the provider or directly to the enrolled subscriber, depending on the state in which services were received and whether there was a valid Assignment of Benefits. Subscribers are responsible for full payment to a non-participating provider according to that office's billing practices.

B. Accessing Benefits

To use the plan, follow these steps:

1. Read this handbook and the Summary of Benefits to become familiar with the benefits, Delta Dental's method of payment and the provisions of the plan.
2. Whenever possible, select a participating provider. Make a dental appointment and tell the dental office that dental coverage is under this plan. If the office is not familiar with the coverage applicable to this plan or has any questions regarding the plan, the dental office may contact the Delta Dental Benefit Service Department at (505) 855-7111 or toll free (877) 395-9420.
3. Following dental treatment, a claim needs to be filed with Delta Dental. All participating Delta Dental dentist offices will file the claim directly with Delta Dental. Non-participating dentists may require patients to file their own claims. Claims for benefits must be submitted to Delta Dental in writing within 12 months from the date services were provided. Failure to submit a claim within the time limitation shall not void or reduce the claim if it is shown it was not reasonably possible to submit within the 12 months, and that the claim was submitted as soon as reasonably possible. If Delta Dental does not respond within 15 days to a request to furnish a dental claim form, the requirements for claims submission shall be deemed to have been met upon the submission to Delta Dental.
4. Patients are responsible for filing claims for services received from a non-participating dentist outside of the United States. A claim form, including the "Patient Section," must be completed. Prior to submission to Delta Dental, the dental office providing services must complete an itemization of services that includes tooth number if applicable, a description of each individual service, a date of service, a fee for each individual service and a signature by the dentist.

Delta Dental will calculate foreign currency benefit payments based on published currency conversion tables that correspond to the date of service.

5. Completed claim forms should be submitted to Delta Dental, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110. The Delta Dental Benefit Service Department is available Monday through Friday, 8:00 am – 4:30 pm (Mountain Time) at (505) 855-7111 or toll free (877) 395-9420.

6. Within 30 days of receiving a valid claim, Delta Dental will send an Explanation of Benefits which records the Delta Dental benefit determination, any payment made by Delta Dental and any amount still owed to the dental provider. The Explanation of Benefits will be mailed to the enrolled person, or other appropriate beneficiary, and to the treating dentist if a Delta Dental participating dentist. The 30-day period for claim determination may be extended an additional 15 days if matters beyond the control of

   Delta Dental delay benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial 30-day period.

7. If a claim for benefits is reduced or denied, the Explanation of Benefits will state the reason for the adverse determination. Should an enrolled person believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the steps described in Section IV, "Claims Review and Appeal Procedures."

C. Out-of-Pocket Expenses

To help keep premium levels affordable, the plan is designed for cost sharing between the enrolled person and Delta Dental for the services provided by a dental provider.

1. **Deductible**

   The plan may require enrolled persons to pay a portion of the initial expense toward some covered services in each benefit period. When applicable, the amount of this deductible is stated in the Summary of Benefits.

2. **Patient Copayment**

   The patient copayment is the percentage of covered services for which the enrolled person is responsible for payment to the dental provider. The amount of patient copayment will vary depending on the level of benefits for the particular dental treatment and the selection of a participating or a non-participating provider as described in the accompanying Summary of Benefits.

3. **Maximum Benefit Amount**

   Delta Dental will pay for covered services up to a maximum amount for each enrolled person for each benefit period. Enrolled persons are responsible for payment of amount due for any dental services that exceeds the maximum benefit applicable in benefit period. The maximum benefit amount is stated in the Summary of Benefits.

D. Clinical Review

1. All claims are subject to review by a licensed, actively practicing dentist (Dental Consultant) who has no affiliation or connection with Delta Dental other than as an independent consultant or a Delta Dental participating provider.

2. Payment of benefits may require that an enrolled person be examined by a licensed dental consultant or an independent licensed dentist.

3. Delta Dental may require additional information prior to approving a claim. All information and records acquired by Delta Dental will be kept confidential.

E. To Whom Benefits Are Paid

1. Delta Dental will pay a participating provider directly for covered services rendered. The enrolled person is responsible for paying the provider directly for any non-covered services.
2. Delta Dental will pay a New Mexico non-participating provider when a valid assignment of benefits is received on the individual claim and when the dentist has a valid National Provider Identifier (NPI) number. The enrollee may be responsible for making full payment to the non-participating provider.
3. Delta Dental will pay a non-participating provider practicing outside the state of New Mexico when required by the Delta Dental member company in that state,

   when a valid assignment of benefits is received on the individual claim and when the dentist has a valid National Provider Identifier (NPI) number.
4. All available benefits not paid to the dental provider shall be payable to the enrolled person or to the estate of the enrolled person.
5. Delta Dental must pay directly to the Human Services Department or Indian Health Services any eligible dental benefits under this Contract which have already been paid or are being paid by the Human Services Department or Indian Health Services on behalf of the enrolled person under the State's Medicaid Program or Indian Health Program.
6. In cases of a Qualified Medical Child Support Order (QMCSO), Delta Dental will send benefit payments directly to participating providers. Payment of benefits for services obtained from non-participating providers will be directed in compliance with the valid order of judgment provided in the QMCSO.

F. Right to Recover Benefits Paid by Mistake

If Delta Dental makes a benefit payment to the enrolled person or to a provider and the patient is subsequently determined as not eligible for all or part of that benefit, Delta Dental has the right to recover payment. The right to recover a payment includes the right to deduct the amount paid from future dental benefits for any covered family member.

III. BENEFITS, LIMITATIONS AND EXCLUSIONS

Unless otherwise specified on the Summary of Benefits, the benefits, limitations and exclusions described in this section apply to this plan. A dental service will be considered for benefits based on the date the service is started. Benefits are subject to processing policies of Delta Dental and the terms and conditions of the entire Contract. Refer to the accompanying Summary of Benefits for patient copayment amounts.

For all enrolled persons, including legally adopted children or children placed with an enrolled person or spouse for adoption, coverage will apply without any pre-existing benefit restrictions.

In addition to the limitations applicable to each type of service, refer to “General Limitations and Exclusions” for a detailed list of other applicable plan exclusions.

A. Diagnostic and Preventive Services

Diagnostic: procedures to aid the dentist in choosing required dental treatment (oral examinations, diagnostic consultations, clinical oral evaluations and x-rays).

Palliative: minor treatment to relieve emergency pain when supporting narrative is submitted by the provider.

Preventive: cleanings, application of fluoride, space maintainers and sealants. Periodontal maintenance is considered to be a cleaning for benefit determination or payment purposes.

Limitations on Diagnostic And Preventive Services

1. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams and clinical oral evaluations and are limited as shown in the Summary of Benefits.
2. Dependents under the age of fourteen (14) are limited to routine child cleanings. Dependents age fourteen (14) and over will be considered adults for the purpose of determining benefits for cleanings.
3. A separate fee for periodontal maintenance is disallowed within three (3) months of other periodontal therapy provided by the same dentist.
4. Full mouth debridement is only a benefit when necessary to enable comprehensive evaluation and diagnosis and is limited to once per lifetime.
5. X-rays exceeding the diagnostic equivalent of a complete series, will be disallowed when taken on the same date of service.
6. Bitewing x-rays exceeding the diagnostic equivalent of a complete set of bitewings, will be disallowed when taken on the same date of service.
7. Emergency palliative treatment does not include services and supplies that exceed the minor treatment of pain.
8. Services for diagnostic casts, photographs, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered.
9. A separate fee for pulp vitality tests is a benefit only in conjunction with an emergency exam or palliative treatment on the same date of service.
10. Benefits for Sealants are limited as shown on the Summary of Benefits and to permanent molars free from occlusal restorations.
11. A separate fee for the replacement of a sealant by the same provider is not allowed within three (3) years of the initial placement.
12. Benefits for space maintainers are limited as are limited to once per lifetime per site.
13. A separate fee for the recementation or repair to a space maintainer by the same provider is not allowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation or repair is a benefit once per twelve (12) month period.
14. A separate fee for the removal of a space maintainer by the same provider who placed the initial appliance is not allowed. Removal of a space maintainer by a different provider is a benefit once per lifetime per space.
15. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

B. Restorative Services

Restorative services are amalgam, resin-based composite restorations (fillings), stainless steel and prefabricated stainless steel restorations. These covered services are a benefit for the treatment of visible destruction of the hard tooth structure resulting from the process of decay or injury.

Limitations on Restorative Services

1. A separate fee for the replacement of a restoration or any component of a restoration on a tooth for the same surface by the same provider is not allowed if done within twenty-four (24) months of the initial service.

2. When multiple restorations involving multiple surfaces of the same tooth are performed, benefits will be limited to that of a multi-surface restoration. A separate benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth subject to clinical review.

3. Resin restorations in posterior teeth are limited to bicuspid and maxillary first molars. On all other teeth, they are considered optional services and are limited to the equivalent amalgam restoration benefit.

4. Prefabricated resin crowns are a benefit for primary anterior teeth only.

5. Preventative restorations are not a covered benefit.

6. Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the benefit for the equivalent amalgam/resin procedure.

7. Services for metallic, porcelain/ceramic or composite/resin onlays are subject to clinical review and limitations on optional services may apply.

8. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture is not covered.

9. Separate fees for more than one pin per tooth or a pin performed on the same date of service as a build-up are not allowed. Pin retention, when dentally necessary, is allowed once per tooth in a twenty-four (24) month period.

10. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

C. Basic Services

Anesthesia: intravenous sedation and general anesthesia.

Endodontics: treatment of dental pulp disease and surgical procedures involving the root.

Extractions: surgical and non-surgical extractions.

Oral Surgery: oral surgery including oral maxillofacial surgical procedures of all hard and soft tissue of the oral cavity.

Periodontics: treatment of diseased gums and bones supporting teeth. For purposes of benefit calculation, a quadrant is defined as four (4) teeth.

Limitations on Basic Services

1. Intravenous (IV) sedation and general anesthesia are not benefits for non-surgical extractions and/or patient apprehension.

2. Intravenous (IV) sedation and general anesthesia are benefits only when administered by a licensed dentist in conjunction with specified surgical procedures, subject to clinical review and when medically necessary.

3. Nitrous oxide and non-intravenous conscious sedation are not covered benefits.

4. Pulpal therapy procedure benefits are limited to once in a 24 month period.

5. A separate fee is not allowed for pulp therapy procedures when performed on the same day, by the same provider, as other surgical procedures involving the root.

6. A separate fee is not allowed for a pulp cap placed on the same day as a restoration or within twenty-four (24) months of a pulp cap placed on the same tooth by the same provider.

7. A pulpotomy or pulpal debridement is a benefit once per tooth per lifetime.

8. Pulpotomies and pulpal therapy procedures are limited to primary teeth.

9. Benefits for certain oral surgery procedures are subject to the receipt of an operative report and clinical review, and may be reduced by benefits provided under the patient's medical benefits coverage, if applicable.

10. Root canal therapy in conjunction with overdentures is not a benefit.

11. Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same provider, within twenty-four (24) months, is considered part of the original procedure and a separate fee is not allowed.

12. Apexification benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is disallowed if performed by the same dentist within 24 months of root canal therapy.

13. Endodontic endosseous implants are not a benefit.

14. Tooth transplantation, including re-implantation is not a benefit.

15. Periodontal scaling and root planing benefits are limited to once per quadrant or site in a two (2) year period.

16. Periodontal surgeries, such as gingivectomy, gingival flap, osseous surgery, bone grafts and tissue graft procedures are limited to once per site in a three (3) year period. A gingivectomy performed on the same date of service as a restoration is an eligible expense.

17. Separate fees for crown lengthening in the same site are disallowed when charged by the same dentist within three (3) years.

18. Additional fees for more than two (2) quadrants of osseous surgery on the same day of service are disallowed.

19. Separate fees for postoperative visits and dressing changes by the same dentist performing the surgery are disallowed.

20. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

D. Major Services

Crown Build-Ups and Substructures: benefits when necessary to retain a cast restoration due to extensive loss of tooth structure from caries, fracture or endodontic treatment.

Crowns, Cast Restorations and Veneers, Including Repairs: benefits when a tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or resin filling.

Implants: specified services, including repairs, and related prosthodontics, subject to clinical review and approval.

Prosthodontics: procedures for construction or repair of bridges, partial or complete dentures.

Limitations on Major Services:

1. Replacement of any crowns, cast restorations, build-ups, implants, substructures or veneers is not a benefit within five (5) years of previous replacement.

2. Replacement of any bridge or denture is not a benefit if the previous placement is less than five (5) years old.

3. Services which are beyond the standard of care customarily provided, or not necessary to restore function are limited to the benefit applicable to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

4. Overdentures are not a covered service.

5. A separate fee for a crown build-up or substructure is disallowed when enough tooth structure is present to retain a cast restoration.

6. Posts and cores in addition to a crown are a benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are disallowed when these requirements are not satisfied.

7. A separate fee for the recementation or repair to crowns, implants, onlays, post and core or bridges within six (6) months of the original treatment by the same provider is disallowed. After six (6) months, these services are a benefit once per twelve (12) months. Procedures to modify existing partials and dentures are considered construction of prosthesis versus the repair of a prosthesis.

8. Surgical placement of eposteal or transosteal implants is not a benefit.

9. Surgical placement of an endosteal implant is a benefit once per tooth per five (5) year period.

10. Implant retained or supported crowns and retainers with metallic alloy content less than high noble are not benefits.

11. Implant maintenance procedures are limited to twice in a benefit period.

12. The replacement of a semi-precision or precision attachment of an implant/abutment supported prosthesis is considered an optional service and is not a benefit.

13. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same provider, is disallowed. After twenty-four (24) months, this service is a benefit once per tooth per lifetime.

14. A separate fee is not allowed for a radiologic surgical implant index.

15. A posterior fixed bridge and a partial denture are not benefits in the same arch. Benefit is limited to the allowance for a partial denture.

16. Temporary restorations, temporary implants and temporary prosthodontics are considered part of the final restoration. A separate fee by the same provider is not allowed.

17. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to bicuspids and maxillary first molars. On all other teeth, they are considered optional services and benefits are limited to the equivalent metal crown or metal implant supported prosthetic benefit.

18. Initial prosthetic placement for congenitally missing teeth is not covered.

19. Maxillofacial prosthetics are not a benefit.

20. Crowns, implants, prosthodontics and all related services are not benefits for dependents under the age of sixteen (16).

21. Fees for full or partial dentures include any reline/rebase, adjustment or repair required within six (6) months of delivery except in the case of immediate dentures. After six (6) months, adjustments to dentures are a benefit twice in a twelve (12) month period and relines or rebases are a benefit once in a three (3) year period.

22. Tissue conditioning is not a benefit more than twice per denture unit in a three (3) year period.

23. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

E. Craniomandibular (CMJ) and Temporomandibular Joint (TMJ) services – treatment related to disorders of the joints that attach the jaw to the skull.

Limitations on treatment related to Craniomandibular (CMJ) or Temporomandibular Joint (TMJ) disorders:

1. 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.

2. Services related to Malocclusion treatment, if part of routine dental care and orthodontics, are not covered.

3. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

F. General Limitations And Exclusions

1. A waiting period prior to obtaining some services applies. This means an enrolled person is not eligible for benefits for those services until he/she has been continually enrolled under this Contract for the time frame stated in the Summary of Benefits.

2. Services for any covered procedures which exceed the frequency or age limitation shown on the Summary of Benefits are not eligible for benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.

3. Services beyond treatment that is considered the standard of care customarily provided, or which are not necessary to restore function, are considered "optional services."

   If an enrolled person receives optional services, benefits may be provided based on the customary or standard procedure. A determination of optional services is not an opinion or judgment on the quality or durability of the service. The enrolled person will be responsible for any difference between the cost of optional services and any benefit payable.

4. Treatment of injuries or illness covered by Workers' Compensation or Employers' Liabilities Laws or services received without cost from any federal, state or local agencies are not a benefit.

5. Services for congenital or developmental malformations are not covered. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), and fluorosis (a type of discoloration of the teeth). Services provided to newborn children enrolled from birth for congenital defects or birth abnormalities are not, however, excluded from coverage.

6. Treatment to restore tooth structure lost from wear unless there is visible decay or fracture on the tooth structure is not covered.

7. Cosmetic surgery or procedures are not covered.

8. Prosthodontic services or any single procedure started before the patient is covered under the plan are not eligible for benefits.

9. Prescribed drugs, pain medications, desensitizing medications and therapeutic drug injections are not covered.

10. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dental or medical provider for treatment in any such facility are not covered services.

11. Extra oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site are not a benefit.
12. Treatment must be provided by a licensed dentist or a person who by law may work under a licensed dentist's direct supervision.
13. A separate charge for office visits, non-diagnostic consultations, case presentations or broken appointments is not covered.
14. Treatment to correct harmful habits is not covered.
15. A separate charge is not allowed for behavior management, infection control, sterilization, supplies, and materials.
16. Charges for services or supplies that are not necessary according to accepted standards of dental practice are not benefits.
17. Charges for services, supplies, or devices which are not a dental necessity are not benefits.
18. Procedures considered experimental or investigational, as determined by Delta Dental, are not covered.
19. A hemisectioned tooth will not be benefited as two (2) separate teeth.
20. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a benefit unless related to covered services for Craniomandibular (CMJ) or Temporomandibular Joint (TMJ) disorders.
21. Treatment to stabilize teeth is not a benefit unless related to covered services for Craniomandibular (CMJ) or Temporomandibular Joint (TMJ) disorders.
22. Occlusal guards or splints are not a benefit unless related to covered services for Craniomandibular (CMJ) or Temporomandibular Joint (TMJ) disorders.
23. Athletic mouth guards are not a benefit.
24. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture is not covered.
25. Separate fees are not allowed for procedures, which are routinely considered by Delta Dental to be part of another service, if performed by the same dentist on the same date of service.
26. Any service not shown on the Summary of Benefits is not covered.

IV. CLAIMS REVIEW AND APPEAL PROCEDURES

Voluntary Appeal Procedure

An enrolled person may request a review of a claim by following Delta Dental claim appeal procedures. All Delta Dental claim appeal procedures are voluntary and are designed to provide a full and fair review of any adverse benefit determination. An adverse benefit determination means a denial, reduction or termination of a benefit or a failure to make payment, in whole or in part, on a claim. This includes a determination based on the enrolled person's eligibility to participate in the plan.

The decision as to whether to request a review or to appeal a claim will have no affect on the patient's right to any other benefits under the plan. In addition, the following provisions are assured. The enrolled person:

- will be notified in writing by Delta Dental of any adverse benefit determination and the reason(s) for the adverse determination;

- may submit written comments, documents, records, narratives, radiographs, clinical documentation and other information relating to the claim which Delta Dental will take into consideration, whether or not such information was submitted or considered in the initial benefit determination;
- shall be provided, upon request and free of charge, reasonable access to and/or copies of all documents, records and other information in the possession of Delta Dental that is relevant to the claim;
- may choose a representative to act on his or her behalf at the enrolled person's expense;
- will not be charged any fees or costs incurred by Delta Dental as part of the voluntary appeals process;
- has 180 days following receipt of a notification of an adverse benefit determination within which to appeal;
- will receive a response to the appeal from Delta Dental in writing within 30 days of receipt of the request;
- is not required to file an appeal prior to arbitration or taking civil action;
- is assured that the review of any adverse benefit determination under appeal will not be conducted by the same person or a subordinate of the person who determined the initial adverse benefit determination.

Informal Claim Review Process

Most claim-related requests may be handled informally by calling the Delta Dental Benefit Services Department at (505) 855-7111 or toll free at (877) 395-9420. Enrolled persons always have the opportunity to describe problems, submit explanatory information and allow Delta Dental to correct any errors quickly.

Formal Claim Appeal Process

If an enrolled person disagrees with a benefit determination, a formal review of the claim may be requested by filing an appeal with Delta Dental within 180 days following receipt of Delta Dental's notification of an adverse benefit determination. An appeal is a formal, written request to change a previous decision made by Delta Dental.

The enrolled person may appeal an adverse benefit determination and request an external peer review by the local or state dental society. Delta Dental will provide the enrolled person with information on how to initiate the peer review process through the New Mexico Dental Association.

All written appeals must be directed to Delta Dental of New Mexico, Attention: Claims Manager, 2500 Louisiana Boulevard. N.E., Suite 600, Albuquerque, NM 87110.

V. TERMINATION OF COVERAGE

Coverage ends when enrollment in the Presbyterian Individual Medical Plan ends or on the last day of any Comprehensive Dental Plan contract period if the member disenrolls from Comprehensive Dental Plan for the next Presbyterian Individual Medical Plan contract period.

If an enrolled person loses coverage, Delta Dental will only pay claims for covered services incurred prior to the loss of coverage.

VI. INDIVIDUAL PLAN MEMBER PROVISIONS

A. Entire Contract Changes

1. No agent or other person, except an officer of Delta Dental, has the authority to waive any conditions or restrictions on dental plan benefits or to bind Delta Dental by making promise or representation or by giving or receiving any information.
2. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an endorsement or amendment in writing signed by one of the aforesaid officers.

B. Time Limit on Certain Defenses

1. After two year from the date of issue of this coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application for the coverage shall be used to void coverage or to deny a claim for loss incurred commencing after the expirations of such two-year period.

C. Legal Actions

1. No legal action at law or in equity shall be brought to recover benefits after the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the dental plan. No such action shall be brought after three years after the time written proof of loss is required to be furnished.

D. Medicaid Assignment

1. Benefits payable by Delta Dental on behalf of an enrollee who is qualified for Medicaid will be paid to the state Human Services Department of its designee, when:
2. the Human Services Department has paid or is paying benefits on behalf of the enroll under the sates Medicaid program pursuant to title XIX and/.or XXI of the Federal Social Security Act; and
3. the payment for the services in question has been made by the state Human Service Department to the Medicaid Provider/Practitioners.

E. Premium Increase

1. An increase in a health insurance premium shall not be effective without sixty days' written notice to the policyholder. Applies to policy, endorsement, rider and application forms.

F. Grace Period

1. In the event any Contract charge, including a prepayment and any applicable finance charge or charges, is not paid when due, a notice of cancellation shall be mailed to the subscriber by first-class mail at his/her current address a legible copy of such notice. Receipt of payment of the Contract charge within 15 days of the issuance of the notice of cancellation shall be sufficient to prevent cancellation and termination under this item.

G. Reinstatement

1. This agreement may reinstate 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.

H. Right to Examine

1. Delta Dental, at its own expense, shall have the right and opportunity to examine a member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

VII. NOTICE OF PRIVACY PRACTICES

This section describes how Delta Dental protects the medical information of enrolled persons. Delta Dental understands that medical and health information is private and is committed to protecting the confidentiality and security of that information.

Delta Dental is required to provide this notice by law, specifically, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Delta Dental must:

- make certain to maintain the privacy of each enrolled person's Protected Health Information;
- provide this notice of our legal duties and privacy practices with respect to Protected Health Information;
- follow the terms of the notice that is currently in effect, and
- describe an enrolled person's rights with respect to Protected Health Information and how enrollees can exercise those rights.

This notice was effective April 14, 2003 and will remain in effect until amended.

Protected Health Information is information that may identify an enrolled person and relate to the past, present or future health, treatment, or payment for health care services for that enrollee. This notice applies to all of the medical records maintained by Delta Dental. An individual's dentist may have different policies or notices regarding the dentist's use and disclosure of medical information created in the dentist's office.

Delta Dental safeguards Protected Health Information from inappropriate use or disclosure. Delta Dental employees, and those of companies that help Delta Dental service the dental plan, are required to comply with Delta Dental requirements that protect the confidentiality of Protected Health Information.
Delta Dental will not disclose Protected Health Information to any other company or person for their use in marketing their products to any individual without the expressed permission of that individual. However, as described in this notice, Delta Dental will use and disclose Protected Health Information about an enrolled person for business purposes to administer the dental plan and when required or authorized by law.

For answers to questions about this notice, contact:

Delta Dental of New Mexico
HIPAA Privacy Office
2500 Louisiana Blvd. NE, Suite 600
Albuquerque, NM 87110
505-883-4777
800-999-0963

This Notice of Privacy Practices is also available on the Delta Dental website: www.deltadentalNM.com

A. How Delta Dental May Use and Disclose Protected Health Information

The following categories describe different ways that Delta Dental is permitted to use and disclose medical information. Not every use or disclosure in a category will be listed.

However, all of the ways Delta Dental is permitted to use and disclose information will fall within one of the categories.

1. Payment: Delta Dental may use and disclose Protected Health Information to determine eligibility for plan benefits, to make benefit payments for the treatment and services received from dentists, to determine benefit responsibility under the plan, to issue premium billings and to coordinate plan coverage. For example, the medical information contained on claims may be used to reimburse dentists for their services. Delta Dental may tell an enrolled person's dentist about dental history to determine whether the plan will cover treatment. Delta Dental may also disclose Protected Health Information to other insurance carriers to coordinate benefit payments with respect to a particular claim.

2. Health Care Operations: Delta Dental may use and disclose Protected Health Information as necessary for company operations. For example, Delta Dental may use medical information in connection with: providing customer service, establishing premiums and underwriting rules, evaluating a request for dental benefit products, administering those products, quality assurance, professional review, and processing transactions requested by an enrolled person. Delta Dental may also disclose Protected Health Information to Delta Dental affiliates, and to business associates outside of Delta Dental, if those affiliates or associates need to receive Protected Health Information to provide a service to Delta Dental and will agree to abide by specific rules relating to the protection of Protected Health Information. Examples of business associates are data processing companies, insurance agents, attorneys, auditors or companies that furnish administrative support or services.

3. Health-Related Benefits or Services: Delta Dental may use Protected Health Information to provide an enrolled person with information about benefits available under the dental plan.

4. Incidental Disclosures: Certain incidental disclosures of Protected Health Information occur as a byproduct of lawful and permitted use and disclosure of Protected Health Information. These incidental disclosures are permitted if Delta Dental applies reasonable safeguards related to Protected Health Information.

5. Others Involved in an Enrolled Person's Healthcare: Unless an enrolled person objects, Delta Dental may disclose Protected Health Information to a member of the enrolled person's family, a relative, or any other person specifically identified, that directly relates to that person's involvement in the enrolled person's health care or payment for health care. If the enrolled person is unable to agree or object to such a disclosure, Delta Dental may disclose such information as necessary in an emergency or if Delta Dental determines that it is in best interest of the enrolled person based on professional judgment.

6. As Authorized by an Enrolled Person: Other uses and disclosures of Protected Health Information not covered by this notice and permitted by the laws that apply to Delta Dental will be made only with an enrolled person's written authorization or that of a legal representative. An enrolled person may authorize Delta Dental to use Protected Health Information or disclose it to another person for a designated purpose. An enrolled person may withdraw the authorization in writing at any time, except to the extent that Delta Dental has taken action relying on the prior authorization, i.e., Delta Dental cannot take back any disclosures already made with authorization.

7. Authorized by Law for Public Benefit: Delta Dental may use or disclose Protected Health Information as authorized by law for the following purposes deemed to be in the public interest:

   - as required by law;
   - to avert a serious threat to health or safety;

- to report to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations;
- for public health activities including reporting births and deaths, victims of abuse or neglect, reaction to medications or problems with products and to prevent or control disease, injury or disability;
- to a coroner, medical examiner or funereal directors to assist in identifying a deceased individual or to determine the cause of death. Delta Dental may also release Protected Health Information for organ donation purposes;
- in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process;
- to federal officials for intelligence, counterintelligence, and other national security activities authorized by law;
- as authorized to comply with workers' compensation laws and other similar legally established programs;
- if an enrolled person is an inmate of a correctional institution or under the custody of law enforcement officials, Delta Dental may release medical information about that enrollee to the correctional institution or law enforcement official; and in response to a court or administrative order if the enrollee or the enrollee's estate is involved in a lawsuit or a dispute. Delta Dental may also disclose Protected Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell the enrollee about the request or to obtain an order protecting the Protected Health Information requested. Delta Dental may disclose Protected Health Information to any governmental agency or regulator with whom the enrolled person has filed a complaint or as part of a regulatory agency examination.

B. Individual Rights Regarding Protected Health Information

The following rights concerning Protected Health Information apply under HIPAA.

An enrolled person may contact Delta Dental at the location listed in this notice to submit a request or for an explanation on how to submit a request, obtain forms, or other additional information.

1. Right to Inspect and Copy Protected Health Information: In most cases, an enrolled person has the right to inspect and obtain a copy of his or her Protected Health Information maintained by Delta Dental. To inspect and copy Protected Health Information, an enrollee must submit a request in writing. If a copy of Protected Health Information is requested, a fee may be charged for the costs of copying, mailing or other supplies associated with the request. However, certain types of Protected Health Information will not be made available for inspection and copying. This includes Protected Health Information collected by Delta Dental in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances Delta Dental may deny a request to inspect and obtain a copy of Protected Health Information. A review of that denial may be requested. An individual chosen by Delta Dental who was not involved in the original decision to deny the request will conduct the review. Delta Dental will comply with the outcome of that review.
2. Right to Amend Protected Health Information: If an enrolled person believes his or her Protected Health Information is incorrect or that an important part of it is missing, the enrollee has the right to ask Delta Dental to amend the Protected Health Information while it is kept by or for Delta Dental. This request, and the reason for the request, must be submitted in writing. Delta Dental may deny the request if it is not in writing or does not include a reason that

supports the request. In addition, Delta Dental may deny the request if it is to amend Protected Health Information that (a) is accurate and complete; (b) was not created by Delta Dental, unless the person or entity that created the information is no longer available to make the amendment; (c) is not part of the Protected Health Information kept by or for Delta Dental; or (d) is not part of the Protected Health Information which would be permitted to inspect and copy.

3. Right to a List of Disclosures: An enrolled person has the right to request a list of the disclosures Delta Dental has made of his or her Protected Health Information. This list will not include disclosures made (a) for treatment, payment, health care operations, (b) for purposes of national security, law enforcement or to corrections personnel, (c) made pursuant to person's authorization or (d) made directly to the enrolled person. The request must be submitted in writing and state the time period applicable to the list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. The request should indicate in what form the list is requested (for example, on paper or electronically). The first list requested within a 12-month period will be free. Delta Dental may charge the individual making the request for responding to any additional requests. Delta Dental will identify the cost involved and the individual making the request may choose to withdraw or modify the request before any costs are incurred.

4. An enrolled person has the right to request a restriction or limitation on Protected Health Information used or disclosed for treatment, payment or health care operations, or request disclosure to someone who may be involved in the care or payment of his or her care, such as a family member. To request a restriction, an enrollee must send the request in writing and tell Delta Dental (1) what information should be limited; (2) whether the limitation would apply to Delta Dental use, disclosure or both; and (3) to whom the limits would apply (for example, disclosures to a spouse or parent). While Delta Dental will consider the request, Delta Dental is not required to agree to it. Delta Dental will not agree to restrictions on Protected Health Information uses or disclosures that are legally required, or which are necessary to administer Delta Dental business.

5. Right to Request Confidential Communications: An enrolled person has the right to request that Delta Dental communicate Protected Health Information in a certain way or at a certain location if the enrolled person informs Delta Dental that communication in another manner may endanger the enrolled person. For example, the enrolled person may request that Delta Dental only makes contacts at work or by mail. To request confidential communications, a request must be sent in writing, which specifies how or where you wish to be contacted. Delta Dental will accommodate all reasonable requests.

6. Right to Receive a Copy of the Notice: An enrolled person may request a copy of our notice at any time by contacting the Privacy Office or by using the website, deltadentalNM.com. If this notice is obtained via the web site or by electronic mail, the enrolled person is also entitled to request a paper copy.

7. Right to File a Complaint: If an enrolled person believes his or her privacy rights have been violated, he or she may file a complaint with Delta Dental or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. There will not be any penalty for filing a complaint. For answers to questions as to how to file a complaint please contact Delta Dental at (505) 883-4777, (800) 999-0963 or HIPAAprivacy@ddpnm.com.

C. Additional Information

Changes to This Notice: Delta Dental reserves the right to change the terms of this notice at any time. Delta Dental reserves the right to make the revised or changed notice effective for Protected Health Information previously received as well as any Protected Health Information received in the future. The effective date of this notice and any revised or changed notice will be included in the notice. Enrolled persons

will receive a copy of any revised notice from Delta Dental by mail or by e-mail, but only if e-mail delivery is offered by Delta Dental and the enrolled person agrees to such delivery.

Further Information: There may have additional rights under other applicable laws. For additional information regarding the Delta Dental HIPAA Medical Information Privacy Policy or general Delta Dental privacy policies, please contact Delta Dental at HIPAAprivacy@ddpnm.com, (505) 883-4777, (800) 999-0963 or write to:

Delta Dental of New Mexico
HIPAA Privacy Office
2500 Louisiana Blvd., NE, Suite 600
Albuquerque, NM 87110

VIII. DEFINITIONS

Allowed Amount: the Maximum Approved Fees determined by Delta Dental and considered for each dental procedure before application of copayment and deductible.

Benefit Period: the time period for accumulating the deductible, the benefit maximum and the time during which frequency limitations apply, as shown in the Summary of Benefits

Benefits: the amount Delta Dental will pay for covered dental services described in Section III, "Benefits, Limitations, and Exclusions," and in the Summary of Benefits.

Contract: the application submitted as the basis for this coverage, the Summary of Benefits and Sections I-VI of this document.

Copayment: the percentage of the dental provider's approved fee due from the enrolled person to the dental provider.

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

Dental Consultant: a licensed, actively practicing dentist who has no affiliation or connection to Delta Dental other than his or her role as an independent consultant and/or his or her contact to participate with other independent dentists in a Delta Dental provider network.

Delta Dental: Delta Dental of New Mexico or Delta Dental Plan of New Mexico, Inc.

Dental Necessity: a service or supply provided by a dentist or other provider that has been determined by Delta Dental as generally accepted dental practice for the enrolled person's diagnosis and treatment. Delta Dental may use dental consultants to determine generally accepted dental practice standards and if a service is a dental necessity. These services or supplies are in accordance with generally accepted local and national standards of dental practice, and not primarily for the convenience of the enrolled person or provider. The services/supplies are the most appropriate that can safely be provided. The fact that a provider has performed or prescribed a service or supply does not mean it is a dental necessity.

Dentist: a duly licensed dentist, legally entitled to practice dentistry at the time and in the place services are provided.

Experimental/Investigational: a treatment, procedure, facility, equipment, drug, device or supply that is not accepted as standard dental treatment for the condition being treated or any items requiring Federal or other governmental agency approval if such approval had not been granted at the time services were rendered. To be considered standard dental practice and not Experimental/ Investigational, the treatment must have met all five of the following criteria:

1. A technology must have final approval from the appropriate regulatory governmental bodies;
2. The scientific evidence as published in peer-review literature must permit conclusions concerning the effect of the technology on health outcome;

3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives; and
5. The technology must be attainable outside the investigational settings.

Maximum: the highest level of the total dollars payable by Delta Dental for covered dental services in a benefit period for each enrolled person.

Maximum Approved Fee: the amount above which a Delta Dental patient may not be charged for a dental service received from a participating provider.

Medical Necessity: a disease, injury or illness exists which would prohibit the safe delivery of standard dental treatment. Treatment, services, and supplies are not medically necessary if made or delivered solely for the convenience of the enrolled person or provider. The fact that a provider has performed or prescribed a procedure or treatment does not mean it is medically necessary.
Delta Dental may use dental consultants to determine if a service is a medical necessity.

Non-Participating Approved Amount: the fee for a single procedure, determined by Delta Dental, for the purpose of calculating payment to a non-participating dentist.

Non-Participating Dentist: a dentist who does not participate in any of Delta Dental's provider networks.

Participating Dentist: a dentist who has agreed to abide by a Delta Dental Participating Dentist Agreement.

Predetermination of Benefits: an advance estimate of benefits payable under the plan as requested by the dental provider prior to performing a recommended treatment for a covered person. A predetermination of benefits is subject to all maximums, deductibles, eligibility and all other plan provisions at the time services are actually performed. A predetermination of benefits is not required as a condition for payment of benefits.

Premium: the monthly amount due to Delta Dental for enrolled persons.

Provider: a legally licensed dentist, or any other legally licensed dental practitioner, rendering services within the scope of that practitioner's license.

Services and Supplies: those services, devices, or supplies that are considered safe, effective, and appropriate for the diagnosis or treatment of the existing condition. Covered services and supplies do not include experimental services, devices, or supplies. For the purposes of this plan, Delta Dental reserves the right to make the final decision as to whether services, supplies or devices are experimental under this definition.

Sound Natural Teeth: those teeth that are either primary (A through T or AS through TS) or permanent (1 through 32 and 51 through 82) dentition that have adequate hard and soft tissue support.

Subscriber: an enrolled person, who is not enrolled as a dependent.

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