INTEL CORPORATION
HMO Benefit Plan
Plan HWH10031 and HWH10032

EFFECTIVE: January 1, 2015
Offered by Intel Corporation
Administered by Presbyterian Health Plan, Inc.
Welcome

This Presbyterian Benefit Booklet (“PBB”) describes Presbyterian Health Maintenance Organization (“HMO”) benefits.

This PBB is intended to provide you with easy-to-understand general explanations of the more significant provisions of your Plan, effective January 1, 2010. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this PBB and Intel Pay, Stock & Benefits Handbook, the Pay, Stock & Benefits handbook shall govern.

This PBB does not imply a contract of employment. Intel Corporation reserves the right to terminate, discontinue, alter, modify, or change this HMO plan or any provision of this HMO plan at any time.

It is your responsibility to read and understand the terms and conditions in the Intel Pay, Stock & Benefits Handbook and this PBB. You are urged to read this PBB carefully and use it to make well-informed benefits decisions for you and your family.
# Table of Contents

I. Schedule of Benefits ..................................................................................................1  
II. Introduction ...............................................................................................................7  
   A. How this HMO plan Works .......................................................................................7  
   B. Important Instructions ...............................................................................................8  
III. Member Rights and Responsibilities .......................................................................9  
   A. Member Rights ...........................................................................................................9  
   B. Member Responsibilities ..........................................................................................11  
IV. General Information ...............................................................................................12  
   A. Medical Necessity .....................................................................................................12  
   B. How to Obtain Primary Care Services ...................................................................12  
   C. Specialist Care ..........................................................................................................13  
   D. Women’s Healthcare Provider/Practitioner ..........................................................13  
   E. Behavioral Health Services ......................................................................................14  
   F. Participating and Non-Participating Providers/Practitioners .....................................14  
   G. No Need to File Claim Forms When You Visit a Participating Provider/Practitioner ...........................................................................................................15  
   H. Obtaining Care After Normal Physician Office Hours .........................................15  
   I. Restrictions on Services Received Outside of the PHP Service Area ..................16  
   J. National Healthcare Provider/Practitioner Network ............................................16  
   K. Dependent Student ...................................................................................................16  
   L. Court Ordered Coverage for Dependent Children ..............................................16  
   M. Non-Custodial Parents .............................................................................................16  
   N. Annual Out-of-Pocket Maximum ...........................................................................17  
   O. Coordination of Your Medical Care .......................................................................17  
   P. Utilization Management Procedures .......................................................................18  
   Q. Health Management Programs .............................................................................18
R. Transition of Care/Continuity of Care ................................................................. 19
S. Advance Directives ................................................................................................. 19
T. Technology Assessment Committee ...................................................................... 19
U. Fraud ...................................................................................................................... 19
V. Federal and State Healthcare/Reform ................................................................. 20
V. Benefits .................................................................................................................. 21
  A. Accidental Injury/Urgent Care/Emergency Healthcare/Observation/ Trauma Services ................................................................. 21
  B. Ambulance Services ............................................................................................ 22
  C. Autism Specific Disorder ..................................................................................... 24
  D. Cancer Clinical Trials ........................................................................................ 24
  E. Clinical Preventive Services ................................................................................. 26
  F. Complementary Therapies ................................................................................... 28
  G. Dental Services Including TMJ/CMJ ................................................................. 30
  H. Diabetes Services ................................................................................................. 31
  I. Diagnostic Services .............................................................................................. 32
  J. Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Surgical Dressing, Eyeglasses/Contact Lenses and Hearing Aids ............................................................. 33
  K. Genetic Inborn Errors of Metabolism (IEM) ..................................................... 35
  L. Home Healthcare Services/Home Intravenous Services and Supplies .......... 36
  M. Hospice Care ........................................................................................................ 37
  N. Hospital Admissions – Inpatient ........................................................................ 38
  O. Mental Health and Alcoholism and Substance Abuse .................................... 39
  P. Nutritional Support and Nutritional Supplements ............................................ 41
  Q. Outpatient Medical Services ............................................................................. 41
  R. Physician Services ............................................................................................... 42
  S. Prescription Drug Benefit (4-Tier) (Outpatient) ................................................ 44
  T. Reconstructive Surgery ....................................................................................... 46
  U. Rehabilitation and Therapy ............................................................................... 47
  V. Skilled Nursing Facility Care .............................................................................. 49
XII. Complaints, Grievances and Appeals ................................................................. 73
   A. Adverse Determination Grievance Review Procedures ..................................... 73
   B. Administrative Grievance Procedures ............................................................... 74
   C. External Review of a Denied Appeal ................................................................. 74
   D. Retaliatory Action ............................................................................................. 75

XIII. Records............................................................................................................... 76
   A. Creation of Non-Medical Records ................................................................. 76
   B. Accuracy of Information ................................................................................ 76
   C. Consent for Use and Disclosure of Medical Records ..................................... 76
   D. Professional Review ........................................................................................ 76
   E. Confidentiality of Protected Health Information/Medical Records ............... 76

XIV. Termination ....................................................................................................... 82

XVII. Glossary of Terms ........................................................................................... 83

Exhibit A - Service Area Map .................................................................................. 95
## I. SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>INTEL HMO PLAN (HWH10031 and HWH10032) Benefits and Coverage</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANNUAL CALENDAR YEAR DEDUCTIBLE</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>ANNUAL OUT-OF-POCKET MAXIMUM</strong></td>
<td>Individual: $6,350 (2x Annual Premium)</td>
</tr>
<tr>
<td></td>
<td>Family: $12,700 (for 2 or more)</td>
</tr>
<tr>
<td><strong>SPECIALTY PHARMACEUTICAL ANNUAL CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong></td>
<td>$1,500 per Calendar Year</td>
</tr>
<tr>
<td><strong>MAXIMUM LIFETIME BENEFIT (Does not include Autism Spectrum Disorder)</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>ON-SITE TAKE CARE CLINIC VISITS</strong> Health for Life Clinic HFLC</td>
<td>$0 Access Fee</td>
</tr>
</tbody>
</table>

### BENEFITS AND COVERAGE

<table>
<thead>
<tr>
<th>PHYSICIAN SERVICES including: Office Visits</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary Care Physician (PCP)</td>
<td>$15 Copayment per visit</td>
</tr>
<tr>
<td>• Specialist</td>
<td>$35 Copayment per visit</td>
</tr>
<tr>
<td>• Video Visits</td>
<td>$0 Copayment per visit</td>
</tr>
<tr>
<td>Home visits if Medically Necessary</td>
<td>$25 Copayment per visit</td>
</tr>
<tr>
<td>Outpatient Surgery (In Physician’s office)</td>
<td>Included in office visit Copayment</td>
</tr>
<tr>
<td>Specialty Pharmaceuticals(^{(1)}) (Injectable forms administered in Physician’s office)</td>
<td>15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>20% Copayment</td>
</tr>
<tr>
<td>• Testing</td>
<td>20% Copayment</td>
</tr>
<tr>
<td>• Serum (extracts)</td>
<td>Included in office visit Copayment (waived if nursing visit only, including Nurse Visit HFLC)</td>
</tr>
<tr>
<td>• Injections</td>
<td>Included in office visit Copayment (waived if nursing visit only)</td>
</tr>
<tr>
<td>Injections such as insulin, heparin and injectable antibiotics</td>
<td>50% Copayment</td>
</tr>
<tr>
<td>Infertility Services including drugs/injections(^{(1)})</td>
<td>$15 Copayment per visit</td>
</tr>
<tr>
<td>On-campus Student Health Center Hospital and Skilled Nursing Care visits</td>
<td>$0 Copayment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITAL SERVICES – Inpatient(^{(1)}) Coverage Includes:</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Room and Board</td>
<td>$250 Copayment per admission</td>
</tr>
<tr>
<td>• Newborn delivery and other Hospital Obstetrical services</td>
<td>$100 Copayment</td>
</tr>
<tr>
<td>• Home Births</td>
<td>$100 Copayment per visit</td>
</tr>
<tr>
<td>• In-Hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• Detoxification</td>
<td>$0 Copayment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL SERVICES – Outpatient</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgeries(^{(1)}) (at facility)</td>
<td>$100 Copayment per visit</td>
</tr>
<tr>
<td>• X-ray and laboratory tests</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• PET(^{(1)})/CAT Scans(^{(1)})</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• Cardiac Cath / GI Lab</td>
<td>$0 Copayment</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Benefit Certification may be required
## I. SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>INTEL HMO PLAN (HWH10031 and HWH10032)</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL SERVICES – Outpatient Continued</strong></td>
<td></td>
</tr>
<tr>
<td>• Radiation Therapy (Non-surgical)</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• Chemotherapy</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>Specialty Pharmaceuticals(^{(1)}) Oral or inhalation forms/Self-administered</td>
<td>15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year</td>
</tr>
<tr>
<td>Specialty Pharmaceuticals(^{(1)}) Intravenous (IV)</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• Magnetic Resonance Imaging (MRI) tests(^{(1)})</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>• Sleep Studies</td>
<td>$50 Copayment per study</td>
</tr>
<tr>
<td>• Administration of blood/blood components</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td><strong>RECONSTRUCTIVE SURGERY(^{(1)})</strong></td>
<td>Included in Hospital Services – Inpatient, Medical Services – Outpatient, and Physician Services</td>
</tr>
<tr>
<td><strong>EMERGENCY ROOM CARE</strong></td>
<td>$100 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies)</td>
</tr>
<tr>
<td>Including trauma services</td>
<td></td>
</tr>
<tr>
<td><strong>URGENT CARE</strong></td>
<td>$50 Copayment per visit</td>
</tr>
<tr>
<td><strong>AMBULANCE SERVICES</strong> including:</td>
<td></td>
</tr>
<tr>
<td>Emergency or high-risk</td>
<td></td>
</tr>
<tr>
<td>- Ground ambulance</td>
<td>$50 Copayment per occurrence</td>
</tr>
<tr>
<td>- Air ambulance</td>
<td>$100 Copayment per occurrence</td>
</tr>
<tr>
<td>Inter-Facility transfer services</td>
<td></td>
</tr>
<tr>
<td>- Ground ambulance</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>- Air ambulance</td>
<td>$100 Copayment per occurrence</td>
</tr>
<tr>
<td><strong>CLINICAL PREVENTIVE SERVICES</strong></td>
<td>$0 Copayment per visit</td>
</tr>
<tr>
<td>Well Child Care including vision and hearing screening</td>
<td></td>
</tr>
<tr>
<td>Preventive physical exam</td>
<td>Included in office visit Copayment (waived if nursing visit only)</td>
</tr>
<tr>
<td>Adult and child immunizations</td>
<td>Included in office visit Copayment</td>
</tr>
<tr>
<td>Office Based Health education</td>
<td>Included in office visit Copayment</td>
</tr>
<tr>
<td>Family planning services</td>
<td>Included in office visit Copayment</td>
</tr>
<tr>
<td>Cytologic Screening (Pap smear)</td>
<td>Included in office visit Copayment</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV) Screening</td>
<td>Included in office visit Copayment</td>
</tr>
<tr>
<td>Mammography</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$0 Copay</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Benefit Certification may be required
# I. SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>INTEL HMO PLAN (HWH10031 and HWH10032) Benefits and Coverage</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WOMEN’S HEALTH CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Gynecological Care</td>
<td>$15 Copayment per visit</td>
</tr>
<tr>
<td>In office Obstetrical/Maternity Care/Prenatal &amp; Postnatal care</td>
<td>$35 Copayment per visit up to a maximum of $150 per pregnancy</td>
</tr>
<tr>
<td>Specialist (i.e. Perinatologist)</td>
<td>$35 Copayment per visit not included in $150 maximum listed above</td>
</tr>
<tr>
<td>Cytologic (Pap smear), Human Papillomavirus (HPV) screening, and Mammograms refer to Clinical Preventive Services</td>
<td>$250 Copayment per admission</td>
</tr>
<tr>
<td>Newborn Delivery and other Hospital Obstetrical Services</td>
<td>$100 Copayment</td>
</tr>
<tr>
<td>Home Birth</td>
<td></td>
</tr>
<tr>
<td>Implantable contraceptive devices</td>
<td></td>
</tr>
<tr>
<td>• Insertion</td>
<td>50% Copayment per insertion</td>
</tr>
<tr>
<td>• Removal</td>
<td>Included in office visit Copayment</td>
</tr>
<tr>
<td>Contraceptive Methods</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• Intrauterine Devices (IUD)</td>
<td></td>
</tr>
<tr>
<td>• Hormone Contraceptive Injections</td>
<td></td>
</tr>
<tr>
<td>• Inserted Contraceptive Devices</td>
<td></td>
</tr>
<tr>
<td>• Implanted Contraceptive Devices</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding support, supplies and counseling</td>
<td>(for one year after delivery)</td>
</tr>
<tr>
<td><strong>DIABETES SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td>$15 Copayment per visit</td>
</tr>
<tr>
<td>Diabetes education</td>
<td>No Copayment</td>
</tr>
<tr>
<td>Diabetic supplies (^1) (Purchased through a Participating Durable Medical Equipment Supplier)</td>
<td>50% Copayment</td>
</tr>
<tr>
<td>Diabetic supplies including Insulin and diabetic oral agents for controlling blood sugar (Purchased through a Participating Pharmacy)</td>
<td>Generic (Preferred) - $10 Copayment</td>
</tr>
<tr>
<td></td>
<td>Brand (Preferred) - $20 Copayment</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred - $35 Copayment</td>
</tr>
<tr>
<td></td>
<td>(Per 30-day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS (RETAIL)</strong></td>
<td></td>
</tr>
<tr>
<td>Included in PHP’s Preferred Drug List</td>
<td>$10 Copay (30 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td>Generic (Preferred) – Tier 1</td>
<td></td>
</tr>
<tr>
<td>Brand (Preferred)</td>
<td>$20 Copay (30 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td>Brand (Non-preferred)</td>
<td>$35 Copay (30 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
</tbody>
</table>

\(^1\) *Benefit Certification may be required*
## 1. Schedule of Benefits

<table>
<thead>
<tr>
<th>INTEL HMO Plan (HWH10031 and HWH10032)</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs (Retail)</strong></td>
<td></td>
</tr>
<tr>
<td>Brand (when a generic equivalent is available)</td>
<td>$10 Copay plus the difference in the cost of the brand and generic (30 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td>Specialty Pharmaceuticals¹ - Oral or inhalation forms/Self-administered</td>
<td>15% to a maximum of $250 per injection up to a Calendar Year Maximum of $1,500</td>
</tr>
<tr>
<td>Specialty Pharmaceuticals¹ – Intravenous (IV)</td>
<td>No Copay</td>
</tr>
<tr>
<td><strong>Prescription Drugs (Mail Order)</strong></td>
<td></td>
</tr>
<tr>
<td>Included in PHP’s Preferred Drug List</td>
<td></td>
</tr>
<tr>
<td>Generic (Preferred)</td>
<td>$20 Copay (90 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td>Brand (Preferred)</td>
<td>$50 Copay (90 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td>Brand (Non-preferred)</td>
<td>$105 Copay (90 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td>Brand (when a generic equivalent is available)</td>
<td>$20 Copay plus the difference in the cost of the brand and generic (90 day supply up to the maximum dosing recommended by the manufacturer)</td>
</tr>
<tr>
<td><strong>Mental Health Services¹</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$15 Copayment per visit</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$250 Copayment per admission</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$250 Copayment per admission (waived if immediately following an Inpatient hospitalization discharge)</td>
</tr>
<tr>
<td><strong>Alcohol and Substance Abuse Services¹</strong></td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>$15 Copayment per visit</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>$250 Copayment per admission</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>$15 Copayment per visit</td>
</tr>
<tr>
<td>• Inpatient or partial hospitalization</td>
<td>$250 Copayment per visit</td>
</tr>
<tr>
<td><strong>Rehabilitation and Therapy Services</strong></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year)</td>
<td>$25 Copayment per session</td>
</tr>
<tr>
<td>Dialysis/Plasmapheresis/Photophoresis</td>
<td>20% Copayment per visit</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation (up to 24 sessions per Calendar Year)</td>
<td>$25 Copayment per session</td>
</tr>
</tbody>
</table>
## 1. SCHEDULE OF BENEFITS

### INTEL HMO PLAN (HWH10031 and HWH10032)

**Benefits and Coverage**

<table>
<thead>
<tr>
<th>REHABILITATION AND THERAPY SERVICES</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>– Continued from previous page</strong></td>
<td></td>
</tr>
<tr>
<td>Short-term Rehabilitation(^{(1)}) (Physical and Occupational Therapy up to 2 months per condition)</td>
<td></td>
</tr>
<tr>
<td>- HFLC</td>
<td>$0 Access fee</td>
</tr>
<tr>
<td>- Inpatient</td>
<td>$250 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Hospice, or Skilled Nursing Facility)</td>
</tr>
<tr>
<td>- Outpatient</td>
<td>$25 Copayment per visit</td>
</tr>
</tbody>
</table>

Speech and Hearing Therapy (up to 2 months per condition)

- Inpatient $25 Copayment per visit

<table>
<thead>
<tr>
<th>TRANSPLANTS(^{(1)})</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$250 Copayment per admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPLEMENTARY THERAPIES (Limited)</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Services (up to 20 visits per Calendar Year if Medically Necessary as specified in Section V.F of the Presbyterian Benefit Booklet)</td>
<td>$25 Copayment per visit</td>
</tr>
<tr>
<td>Chiropractic Services (up to 20 visits per Calendar Year if Medically Necessary)</td>
<td>$25 Copayment per visit</td>
</tr>
<tr>
<td>Biofeedback for specific conditions</td>
<td>$15 Copayment per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SKILLED NURSING FACILITY(^{(1)}) (Up to 60 days per Calendar Year)</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Rehabilitation, or Hospice Facility)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOME HEALTH CARE SERVICES(^{(1)})/ HOME INTRAVENOUS SERVICES(^{(1)})</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided by an RN, LPN and other specified specialist</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>Home intravenous services and supplies</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>Specialty Pharmaceuticals(^{(1)}) Oral or inhalation forms/Self-administered</td>
<td>15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year</td>
</tr>
<tr>
<td>Specialty Pharmaceuticals(^{(1)}) Intravenous (IV)</td>
<td>$0 Copayment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPICE CARE(^{(1)})</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$250 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Rehabilitation, or Skilled Nursing Facility)</td>
</tr>
<tr>
<td>In-home</td>
<td>$0 Copayment</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Benefit Certification may be required
## I. SCHEDULE OF BENEFITS

### INTEL HMO PLAN (HWH10031 and HWH10032)

**Benefits and Coverage**

### DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES\(^{(1)}\)
- Hearing Aids (for school aged children under age 18 or 21 year of age if still attending high school)

  50% Copayment
  Up to $2,200 every 36 months “per hearing impaired ear”

### EYEGLASSES AND CONTACT LENSES

Limited to the following:
- Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus, or when related to Genetic Inborn Errors of Metabolism
- Refraction eye exam associated with post cataract surgery or Keratoconus correction

50% Copayment
Included in office visit Copayment

### DENTAL SERVICES/(CMJ/TMJ) (Limited)

Included in office visit Copayment

### Autism Spectrum Disorder\(^{(1)}\)

Treatment through or provided by:
- PCP
- Specialist
- Outpatient Physical Therapy
- Outpatient Occupational Therapy
- Outpatient Speech Therapy
- Applied Behavioral Analysis (ABA)\(^{(1)}\)

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$15 Copay per visit</td>
</tr>
<tr>
<td>Specialist</td>
<td>$35 Copay per visit</td>
</tr>
<tr>
<td>Outpatient Physical Therapy</td>
<td>$25 Copay per visit</td>
</tr>
<tr>
<td>Outpatient Occupational Therapy</td>
<td>$25 Copay per visit</td>
</tr>
<tr>
<td>Outpatient Speech Therapy</td>
<td>$25 Copay per visit</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA)(^{(1)})</td>
<td>$35 Copay per visit</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Benefit Certification may be required
II. INTRODUCTION

A. How this HMO plan Works

Intel Corporation classifies the Health Maintenance Organization (HMO) as a traditional plan. The HMO typically has higher paycheck contributions and you pay a copayment at the time of service. HMOs encourage preventive care and promote wellness programs (e.g., smoking cessation, health club discounts) and offer benefit coverage levels similar to the national plan.

In most cases, you must live or work within the Presbyterian Health Plan (PHP) Service Area to enroll in this Plan. Contact the Intel Health Benefits Center (877) GoMyBen (455-9236) if you have any questions regarding eligibility for this HMO plan administered by PHP.

PHP’s Service Area is described in Exhibit A of this PBB. PHP strives to work closely with you (employee), your covered Dependents, and their healthcare Providers/Practitioners to prevent illness and provide quality, cost-effective healthcare. You and your covered Dependents are considered Members of this HMO plan (to be referred as the “HMO plan” throughout this document).

You and your covered Dependents must select a Participating Primary Care Physician (PCP) to manage his/her healthcare needs. Your PCP will be able to meet most of these needs. A list of Providers/Practitioners who serve as Participating PCPs may be found in the PHP Provider Directory. PCPs include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). As a Member of this Plan, you may choose as your PCP any doctor or nurse Practitioner on that list. **If you do not designate a Primary Care Physician, PHP will select one for you.**

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

Non-Participating Providers/Practitioners may require you to pay them directly at the time of service; you will then have to file your claim for reimbursement with PHP within one year from the date of service. PHP will only pay a Non-Participating Provider/Practitioner claim if the service provided was Certified by PHP or was due to an emergency or an urgent condition.
Please send your bill or claim to us at the following address:

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

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

B. Important Instructions

This PBB, together with the Intel Pay, Stock & Benefits Handbook, describes your benefits, rights and responsibilities as a Member of this Plan. It also gives details on how to choose or change your Primary Care Physician, what limits are placed on certain benefits, and what services are not Covered at all. Please take the time to read this PBB carefully and then store it in a safe place for future reference. If you have any questions after reading this PBB, please call the Intel Health Benefits Center (877) GoMyBen (455-9236) or the Presbyterian Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY/TDD users may call 1-877-298-7407. You may also contact a Presbyterian Customer Service Representative by e-mail at info@phs.org.
III. MEMBER RIGHTS AND RESPONSIBILITIES

Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your health plan. (This information can also be found on Presbyterian’s website at www.phs.org.) 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 Plan Members have a right to:

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

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

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

4. participate with treating Practitioners in making decisions about their healthcare.

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

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

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

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

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

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

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

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

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

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

16. change Primary Care Physicians by following the rules described in Section IV. (General Information) item B. (How to Obtain Primary Care Services) of this Presbyterian Benefit Booklet (“PBB”).

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

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

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

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

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

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

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

24. receive a complete explanation of why services or benefits are denied, an opportunity to Appeal the decision to PHP, and the right to a Voluntary Appeal as described more fully in the Intel Pay, Stock & Benefits Handbook;
25. receive a Certificate of Creditable Coverage when a Member’s enrollment in this Plan terminates.

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

B. Member Responsibilities - All Plan Members must:

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

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

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

4. review their PBB and if there are questions contact our Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY/TDD users may call 1-877-298-7407. You may also contact a Presbyterian Customer Service Representative by e-mail at info@phs.org for clarification of benefits, limitations, and exclusions outlined in this PBB.

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

6. notify Intel Corporation within 30 days of any change of name, address, marital status, eligible Dependents or newborns.

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

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

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

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

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

A. Medical Necessity

This HMO plan helps pay for healthcare expenses that are Medically Necessary and Specifically Covered in this PBB.

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

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

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

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

Specifically Covered Benefits are subject to the following:
   a. the limitations, exclusions and other provisions of this PBB; and
   b. payment by the Member of the Copayment amount, if any, directly to the Provider/Practitioner of healthcare services at the time services are rendered.

B. How to Obtain Primary Care Services

To receive care under this HMO plan, you and all Covered Member’s of your family must select a Participating Primary Care Physician (PCP) to manage your healthcare needs. Primary Care Physicians include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians and Obstetricians/Gynecologists (if applicable). Establishing a relationship with your Primary Care Physician is an important part of your healthcare benefits. Remember to contact or see your PCP before you seek medical treatment. Your PCP’s role extends far beyond treating you when you are ill; he or she understands the importance of preventing illness and promoting healthier lifestyles. Your PCP expects to manage all of your health concerns and develop an understanding of your health history.
You may want to ask relatives or friends if they have a PCP they would recommend. A Physician may not be a PCP for him/herself or immediate family members. If you do not designate a PCP on your enrollment form, PHP will select one for you. You may change your PCP by contacting PHP Customer Service Center. The requested change will be effective the next business day after you call our Customer Services Center.

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

C. Specialist Care

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

PHP does not require a paper referral from your Primary Care Physician (PCP) for your visits to specialists. However, it is important to your healthcare that your PCP is included in the decisions about the specialists that you visit. Your PCP continues to be your partner for good health and is the best person to help you determine your needs for specialty care. Effective communication about your medical history and treatment between your PCP and the specialists that provide care for you is very important so that the best decisions can be made about your medical care. We recommend that you contact your PCP’s office regarding your desire to visit a specialist. Please note that some specialists may require written referral even though PHP does not.

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

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

D. Women’s Healthcare Provider/Practitioner

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

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

F. Participating and non-Participating Providers/Practitioners

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

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

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

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

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

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

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

2. Competency – The Participating Provider/Practitioner does not have the necessary training or expertise required to render the service or treatment.
3. Geography – The Participating Provider/Practitioner is not located within a reasonable distance from the patient’s residence. A “reasonable distance” is defined as travel that would not place the Member at any medical risk.

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

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

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

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

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

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

H. Obtaining Care After Normal Physician Office Hours

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

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

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

J. National Healthcare Provider/Practitioner Network

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

K. Dependent Student

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

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

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

L. Court Ordered Coverage for Dependent Children

If an Employee who is eligible for family Coverage has been ordered by a court to provide health insurance Coverage for a Dependent child who is eligible for the plan, and that child does not live in the PHP Service Area, please contact the Intel Health Benefits Center (877) GoMyBen (455-9236) for coverage information.

M. Non-Custodial Parents

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

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

2. Permit the custodial parent or the Provider/Practitioner, with the custodial parent’s approval, to submit claims for Benefits without the approval of the non-custodial parent; and
3. Make payments on claims submitted in accordance with (2) above directly to the custodial parent, the Provider/Practitioner or the state Medicaid agency.

N. Annual Out-of Pocket Maximum

This HMO plan includes an Annual Out-of-pocket Maximum amount to help protect you and your Dependents from the high cost of catastrophic illness, the total Medical and Prescription drug Copayments (excluding access fees for the On-site Take Care Clinic visits) for any Calendar Year may not exceed 200 percent (2 x a Member’s annual premium) of the annual total of all premiums paid for you and your Dependents. After your Out-of-Pocket is reached, the Plan pays 100% of Covered Medical and Prescription Drug services (excluding access fees for the On-site Take Care Clinic visits) for the remainder of that Calendar Year, up to the maximum benefit amounts if any.

O. Coordination of Your Medical Care

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

1. treatment plans for rehabilitation and therapies,
2. admission to the Hospital or Skilled Nursing Facilities,
3. the length of stay that is required,
4. emergency admissions to non-contracted Hospitals (for example, emergencies while you are on vacation),
5. Hospice care,
6. visits to non-Participating Providers/Practitioners,
7. care at home following a hospitalization, and
8. disease management.

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

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

1. Your particular plan Coverage for the requested service.
2. Meeting the requirements of your PBB or HMO plan.
3. The service is medically appropriate for your clinical situation
4. Urgent or Emergency Healthcare services, which do not require a Benefit Certification. Other factors, which are considered, include:

1. your age;
2. complications of treatment, adequate progress of and response to treatment plan;
3. other medical conditions;
4. psychosocial situations;
5. home environment; and
6. adequate healthcare services in your area.

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

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

1. case management;
2. catastrophic care;
3. transition of care; and
4. health information/medical records.

P. Utilization Management Procedures

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

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

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

Q. Health Management Programs

PHP’s clinically trained professionals work with your doctor to help enhance your quality of life in three areas: staying healthy, living with illness, and getting better. We help you reach optimum health through preventive health services (such as mammography and childhood
immunizations) as well as, with disease management for conditions such as asthma, depression, diabetes, smoking cessation, and high-risk pregnancies. If you’d like more information about these services, please call our Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY/TDD users may call 1-877-298-7407. You may also contact a Presbyterian Customer Service Representative by e-mail at info@phs.org.

R. Transition of Care/Continuity of Care

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

S. Advance Directives

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

T. Technology Assessment Committee

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

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

U. Fraud

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

If you suspect that a Physician, Pharmacy, Hospital or other healthcare Provider/Practitioner has 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).
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 PHP at (505) 923-5959 or toll-free at 1-800-239-3147.

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

1. Falsifying enrollment information.
2. Allowing someone else to use your ID Card.
3. Forging or selling prescriptions.
4. Misrepresenting a medical condition in order to receive benefits to which you would not normally be entitled.

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

V. Federal and State Health Care Reform

Intel shall comply with all applicable federal laws, rules and regulations. In addition, upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects Intel’s obligations under this Member Benefit Booklet, this Member Benefit Booklet will be deemed automatically amended such that Intel shall remain in compliance with the obligations imposed by such law, rule, or regulation.
V. BENEFITS

A. Accidental Injury/Urgent Care/Emergency Healthcare/Observation/Trauma Services

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

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

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

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

2. Emergency Health Services

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

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

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

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

   (1) a reasonable person’s belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment;
   (2) the time of day the care was provided;
   (3) the presenting symptoms;
   (4) any circumstance that prevented the Member from using PHP’s established procedures for obtaining Emergency Health Services.

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

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

f. If a Member’s Emergency Health Services results in a hospitalization directly from the emergency room, the Member is responsible for paying the Inpatient Hospital Copayment rather than the emergency room visit Copayment.
g. For emergencies in PHP’s Service Area, the Member should seek medical treatment from Participating Providers/Practitioners whenever possible.

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

i. Follow-up care from Non-participating Providers/Practitioners requires a Benefit Certification from PHP.

j. For emergencies outside PHP’s Service Area, the Member may seek Emergency Health Services from the nearest appropriate facility where emergency medical treatment can be rendered. Non-emergent follow-up care outside of PHP’s Service Area is not Covered unless transfer to a Participating Provider/Practitioner would be medically inappropriate and a risk to the Member’s health. In such circumstances the services must be Certified by PHP. Non-emergent follow-up care outside of PHP’s Service Area is not Covered for the convenience or preference of the Member. The Member is responsible for any such charges that are not Certified by PHP.

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

3. Observation Services

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

B. Ambulance Services

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

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

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

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

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

e. In determining whether the Member “acted in good faith” as a “reasonable layperson” when obtaining emergency Ambulance Services, PHP will take the following factors into consideration:
   (1) whether the Member required Emergency Health Services, as defined above;
   (2) the presenting symptoms;
   (3) whether a layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered the Member’s health;
   (4) whether the Member was advised to seek an ambulance by his/her Primary Care Physician or by PHP. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this PBB.

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

   a. non-emergency; and
   b. Medically Necessary for transporting a high-risk patient; and
   c. prescribed by the Member's Physician.

Coverage for High-Risk Ambulance Services is limited to:

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

b. Maternity/Neonatal Ambulance Services, including ground or air ambulance transportation to the nearest Tertiary Care Facility
   (1) for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant; or
   (2) when necessary to protect the life of a newly born child.

c. Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.
3. **Inter-Facility Transfer Services** are defined as ground or air ambulance transportation between any of the following: Hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are Covered only if they are:
   a. Medically Necessary;
   b. prescribed by the Member's Physician; and
   c. provided by a licensed Ambulance Service in a vehicle, which is equipped and staffed, with life-sustaining equipment and personnel.

C. **Autism Spectrum Disorder**

   The diagnosis and treatment for Autism Spectrum Disorder is covered for children, from birth to age nineteen (19) (or up to age twenty-two (22) if enrolled in high school) in accordance with state mandates (Senate Bill 39) as follows:

   1. Diagnosis for the presence of Autism Spectrum Disorder when performed during a well child or well baby screening; and/or

   2. Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis (ABA) to develop, maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative in nature.

   These services are only covered when a treatment plan is provided to Presbyterian Health Plan’s Health Services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with Senate Bill 39.

   Autism Spectrum Disorder Services must be provided by Participating Providers/Practitioners who are certified, registered or licensed to provide these services. Applied Behavioral Analysis (ABA) and other Autism Spectrum Disorder services may require Benefit Certification prior to being provided. If Benefit Certification is not obtained when required, the claim may be denied.

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

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, 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 if:
   a. The Cancer Clinical Trial is undertaken for the purposes of the prevention of or the prevention of the 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 Clinical Trial Test must be conducted with the approval of a federal organization such as National Institutes of Health or the FDA.

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

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

6. Exclusions: In addition to the exclusions listed in Section VIII. (Exclusions) of this PBB, the following are not Covered:
   a. Any Cancer Clinical Trials provided outside of New Mexico as well as, those that do not meet the requirements indicated in items 1-5 above.
   b. Costs of the Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.
   c. Services from Non-participating Providers/Practitioners, unless services from a Participating Provider/Practitioner are not available. Any Non-participating services must be Certified by PHP and provided for in New Mexico.
d. The cost of a non-FDA-approved investigational drug, device or procedure.

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

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

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

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

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

E. **Clinical Preventive Services**

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

1. Preventive Physical Examinations including:

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

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

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

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

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

3. Vision and Hearing Screening performed only by the PCP to determine the need for vision and hearing correction. This does not include routine eye exams or Eye Refractions performed by eye care specialists. One Eye Refraction per Calendar Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases. Hearing aids and the evaluation for the fitting of hearing aids is not Covered except for school aged children under age 18 years old (or under 21 years of age if 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. Meningococcal Vaccine is Covered for freshmen living in college dormitories. 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 Primary Care Physician or as requested by the parents or legal guardian) education information on Alcohol and Substance Abuse, sexually-transmitted diseases, and contraception. For Members 19 years of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.

8. Smoking Cessation. For information regarding Smoking Cessation Programs refer to item W. (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 for the Human Papillomavirus, as approved by the Food and Drug Administration, for females nine (9) to 14 years of age used for the prevention of Human Papillomavirus infection and cervical pre-cancers. In addition, the HPV vaccine is covered for other populations in accordance with guidelines established by The Advisory Committee on Immunization Practices (ACIP).

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

13. Preventive Services for Women

1. Well-woman visits to include adult and female-specific screenings and preventive benefits.
   a. Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery.
   b. Counseling for HIV, sexually transmitted diseases and domestic violence and abuse.
   c. Domestic and interpersonal violence screening and counseling for all women.
   d. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women.
      (1). Generic birth control
      (2). Intrauterine devices (IUD)
      (3). Hormone contraceptive injections
      (4). Inserted contraceptive devices
      (5). Implanted contraceptive device
   e. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
   f. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
   g. Human Papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
   h. Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling.
   i. Sexually Transmitted Infections (STI) counseling for sexually active women.
   j. Sterilization services for women only. Other services during procedure are subject to deductible and co-insurance as outlined in your Summary of Benefits.
   k. Well-woman visits to obtain recommended preventive services for women under 65.


Please refer to your formulary on the Pharmacy page at http://www.phs.org/PHP/programs/pharmacy/formulary/index.htm to review the list of contraceptive products that will not apply a copayment/co-insurance.

F. Complementary Therapies

The only alternative/complementary therapies that are Covered are those that are identified in this PBB.
1. **Acupuncture (Limited)**

Acupuncture services are available subject to the following limitations:

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

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

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

2. **Chiropractic Services (Limited)**

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

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

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

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

d. Chiropractic x-rays are only Covered when performed by a chiropractor for the following clinical situations, unless clinically relevant x-rays already exist:
   1. acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents;
   2. clinical evidence of significant osteoporosis: recent fracture of the spine, wrist or hip; loss of height over ½ inch, or spine curvature consistent with osteoporotic fractures; or
   3. abnormal neurologic or orthopedic findings suggesting spinal nerve impingement.

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

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

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

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

3. **Biofeedback (Limited)**

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

4. Hypnotherapy (Limited)
   Hypnotherapy is only Covered when performed by an anesthesiologist or psychiatrist
   trained in the use of hypnosis when:
   a. used within two weeks prior to surgery for chronic pain management; or
   b. for chronic pain management when part of a coordinated treatment plan.

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

G. Dental Services Including Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)
   Dental services will be provided only in connection with the following conditions when
deemed Medically Necessary except in an emergency situation as described in Section V.
(Benefits) item A. (Accidental Injury/Urgent Care/Emergency Healthcare/Observation/Trauma
Services).

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

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

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

4. The Surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders
   (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ
   splints) are subject to the same conditions, limitations, and Benefit Certification procedures
   as are applicable to treatment of any other joint in the body. Orthodontic appliances and
   treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are specifically excluded, unless the disorder is
   trauma-related.

5. Services related to Malocclusion treatment, if part of orthodontics or routine dental care,
   are not Covered.

6. Hospitalization, day surgery, outpatient services and/or anesthesia for
   non-Covered dental services are not Covered if provided in a hospital or ambulatory
   surgical center for dental surgery when approved by PHP. HMO 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.

7. Oral surgery Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.

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

9. Dental implants are not Covered.

H. Diabetes Services

1. This HMO plan provides Coverage for individuals with insulin dependent (Type I) diabetes, non-insulin dependent (Type II) diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). PHP will guarantee Coverage for the equipment appliances, Prescription Drug, insulin or supplies that meet food and drug administration approval, and are the medically accepted standards for diabetes treatment, supplies and education.

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

   a. Diabetes self-management training, limited to:
      
      (1) Medically Necessary visits upon the diagnosis of diabetes;
      
      (2) visits following a Physician diagnosis that represents a significant change in condition or symptoms requiring changes in the patient’s self-management; and
      
      (3) visits when re-education or refresher training is prescribed by a healthcare Provider/Practitioner with prescribing authority.

   b. Medical nutrition therapy related to diabetes management.

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

3. **Diabetes Supplies and Services.** When prescribed by the Member’s Physician the following equipment, supplies, appliances, and services are Covered for Members with diabetes. These items must be purchased at a Participating Pharmacy or Durable Medical Equipment (DME) supplier.
a. Prescriptive diabetic oral agents for controlling blood sugar levels.
b. Medically Necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment, when Certified by PHP.
c. Glucagon emergency kits.

The following items (d. through l.) require use of PHP approved brands and must be purchased at a Participating Pharmacy or Durable Medical Equipment (DME) supplier. Please contact our Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 pm. TTY users may call 1-877-298-7407. Visit our website at www.phs.org for further information.

d. Blood glucose monitors/meters (Durable Medical Equipment), approved by PHP.
e. Specialized monitors/meters for the legally blind when Certified by PHP.
f. Test strips for blood glucose monitors.
g. Visual reading urine and ketone strips.
h. Lancets and lancet devices.
i. Insulin.
j. Injection aids, including those adaptable to meet the needs of the legally blind.
k. Syringes.
l. Insulin pumps when Medically Necessary, prescribed by a participating endocrinologist, and Certified by PHP.

I. Diagnostic Services

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

1. cardiac procedures including, but not limited to, EKG, EEG, echocardiograms and MUGA scans;
2. clinical laboratory tests;
3. CT Scans;
4. endoscopy procedures;
5. gastrointestinal lab procedures;
6. Magnetic Resonance Imaging (MRI) tests;
7. pulmonary function tests;
8. radiology/x-ray services;
9. ultrasound procedures;
10. sleep disorder studies;
11. bone density studies.
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 PHP, the purchase of Durable Medical Equipment is Covered when required for therapeutic use, determined to be Medically Necessary by the Member's Physician and if Certified by PHP. Only Durable Medical Equipment considered standard and/or basic items are Covered.

   **Exclusions:**
   a. Upgraded or deluxe items.
   b. Items considered “for convenience”. A convenience item is an appliance, device, object or service that is for comfort and ease and is not primarily medical in nature. Examples include but are not limited to:
      1. Shower stools/chairs/seats,
      2. Bath grab bars,
      3. Shower heads,
      4. Vaporizers,
      5. Wheelchair/walker/stroller accessories such as baskets, trays, seats or shades.
   c. Duplicate DME items (i.e. for home and for office).

2. **Orthotic Appliances**

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

3. **Prosthetic Devices**

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

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

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

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

   b. **Exclusions:**
      1. Repair and replacement due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience.
      2. Repair and replacement of items under the manufacturer or supplier’s warranty.
      3. If the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair, additional wheelchair(s) are not Covered. One-month rental of a wheelchair is Covered if a Member owned the wheelchair that is being repaired.

5. **Surgical Dressing**

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

   b. Gradient compression stockings are Covered up to two pairs per Calendar Year for:
      1. Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation or;
      2. Venous stasis ulcers that have been treated by a Physician or other healthcare professional requiring Medically Necessary debridement (wound cleaning).

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

   d. **Exclusions related to Surgical Dressings:**
      1. Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze (such as 4 by 4’s) and ace bandages, except when provided in a Hospital or Physician’s office or by a home health professional.
      2. Gloves unless part of a wound treatment kit.
      3. Elastic support hose.

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

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

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

   b. One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is Covered within 12 months after cataract surgery or when related to Genetic Inborn Errors of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.
c. **Exclusions relating to Eye Refractions, Eyeglasses and Contact Lenses:**
   
   (1) Except as above, routine vision care, Eye Refractions, corrective eyeglasses, sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof.
   
   (2) Routine vision care and Eye Refractions for determining eyeglass or contact lens prescriptions.
   
   (3) Eye refractive procedures including radial keratotomy, laser procedures, and other techniques.
   
   (4) Visual training.

7. **Hearing Aids**

   Hearing aids and the evaluation for the fitting of hearing aids are not Covered 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 in New Mexico.

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

1. Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism where there are standard methods of treatment, when Medically Necessary and subject to **the limitations listed in Section VII. (Limitations), the exclusions listed in Section VIII. (Exclusions)** and the Benefit Certification requirements listed in Section VI. (Benefit Certification) of this PBB. Medical services provided by licensed healthcare professionals, including Physicians, dieticians and nutritionists, with specific training in managing Members diagnosed with Genetic Inborn Errors of Metabolism are Covered. Covered services include:
   
   a. nutritional and medical assessment,
   
   b. clinical services,
   
   c. biochemical analysis,
   
   d. medical supplies,
   
   e. Prescription Drugs ,
   
   f. corrective lenses for conditions related to Genetic Inborn Errors of Metabolism,
   
   g. nutritional management,
   
   h. Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status when Certified by PHP’s pharmacy department.

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

2. **Exclusions:**

   a. Food substitutes for lactose intolerance including soy foods or formulas or other Over-The-Counter (OTC) digestive aids, unless listed as a Covered OTC medication on the Preferred Drug Listing.
   b. Organic foods,
   c. Ordinary foodstuffs that might be part of an exclusionary diet,
   d. Food substitutes that do not qualify as Special Medical Foods,
   e. Any product that does not require a Physician’s prescription,
   f. Special Medical Foods for conditions that are not present at birth,
   g. Food items purchased at a health food, vitamin or similar store,
   h. Foods purchased on the Internet, and
   i. Special Medical Foods for conditions including, but not limited to: Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, and Allergies to food products.

3. **Copayments**

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

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

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

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

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

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

   4. Total parenteral and enteral nutrition as the sole source of nutrition, when Certified by PHP.
5. Specialty Pharmaceuticals as described in Section V. (Benefits) item S. (Prescription Drug Benefit (4-Tier) (Outpatient) when provided by a Home Health Agency, and when Certified by PHP. Refer to the Schedule of Benefits for the required Copayment for Specialty Pharmaceuticals.

M. Hospice Care

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

2. The Hospice benefit period is defined as follows:
   a. beginning on the date the Member's Physician certifies that the Member is terminally ill with a life expectancy of six months or less; and
   b. ending six months after it began, except as described in item c. below, or upon the death of the Member;
   c. if a Member requires an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and the Member's Primary Care Physician must recertify the Member's medical condition to PHP. No more than one additional Hospice benefit period will be Certified by PHP.

3. The following services will be Covered under the Hospice benefit (where a certified Hospice program is available):
   a. Inpatient Hospice care;
   b. Physician visits by participating Hospice Physicians;
   c. home healthcare 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 PBB subject to the Member's Copayment requirements:

   a. Acute Inpatient Hospital care for curative services;
   b. Durable Medical Equipment;
   c. Physician visits by other than a participating Hospice Physician; and
   d. Ambulance Services.

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

N. **Hospital Admissions- Inpatient**

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

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

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

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

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

2. Anesthetics, oxygen, and Covered medications.

4. Diagnostic Services, as specified in Section V. (Benefits) item I. (Diagnostic Service).
5. Dressings, casts and special equipment when supplied by the Hospital for use in the Hospital.
6. Facilities: use of operating, delivery, recovery and treatment rooms and equipment and all other facilities.
7. Meals and special diets or parenteral (intravenous) nutrition.
8. Physician and surgeon services.
9. Private room and board accommodations when Medically Necessary and Certified by PHP.
10. Semi-Private room and board accommodations, including general duty nursing care.
11. Special services and procedures, such as special duty nursing, when Certified by PHP.
12. Surgery, when Certified by PHP. Cosmetic Surgery is not Covered. Examples of Cosmetic Surgery include, but are not limited to, breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except when used for truncal veins), and nasal rhinoplasty.
13. Therapeutic and support care, services, supplies, appliances, and therapies including care in specialized intensive and coronary care units, radiation therapy and inhalation therapy.

O. Mental Health and Alcoholism and Substance Abuse

1. Mental Health Services
   To receive services relating to mental health Members may call the PHP Behavioral Health Department directly at (505) 923-5470 or toll-free at 1-800-453-4347 or self-refer to a Participating Behavioral Health Provider/Practitioner. The Behavioral Health Provider/Practitioner will be responsible for any additional Benefit Certification.
   a. Acute Inpatient mental health services will be Covered when performed by a Participating Provider/Practitioner and when Certified by PHP. Coverage is provided for Inpatient mental health and partial hospitalization.
   b. Partial hospitalization can be substituted for the Inpatient mental health services when Certified by PHP’s Behavioral Health Department. Partial hospitalization is a non-residential, Hospital-based day program that includes various daily and weekly therapies. The Copayment will be waived if the partial hospitalization immediately (within 24 hours or the next business day) follows an Inpatient Hospital discharge.
   c. Outpatient, non-Hospital based, evaluative and therapeutic mental health services are provided when deemed Medically Necessary and Certified by the PHP Behavioral Health Department.
   Acute medical detoxification benefits are Covered under Inpatient and Outpatient Medical Services found in Section V. (Benefits) item N. (Hospital Admissions–Inpatient) and item Q. (Outpatient Medical Services) of this PBB.
   d. Exclusions:
      In addition to the exclusions listed in Section VIII. (Exclusions) of this PBB, the
following are not Covered:
(1) Co-dependency treatment;
(2) Counseling: sex, pastoral/spiritual, and bereavement counseling;
(3) psychological testing when not Medically Necessary;
(4) special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or behavioral problems. This applies whether or not associated with manifest mental illness or other disturbances;
(5) Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy;
(6) Alcohol and/or Substance Abuse are not considered mental health benefits.

2. Alcoholism Services and Substance Abuse Services.

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

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

b. Inpatient treatment in a Hospital or Substance Abuse treatment center will be Covered when Certified by PHP’s Behavioral Health Department.

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

d. Intensive and standard outpatient evaluative and therapeutic services for Alcoholism and Substance Abuse will be provided if Certified by PHP’s Behavioral Health Department. Intensive outpatient Alcohol and/or Substance Abuse Services are defined as visits lasting three hours per visit and attended by the Member three times per week. Standard outpatient therapy visits are defined as outpatient visits last up to 50 minutes.

e. An episode of treatment will be considered complete if any one of the following occurs:
   (a) the Member is discharged on medical advice from Inpatient treatment, partial hospitalization and/or outpatient services; or
   (b) the Member has reached the annual maximum benefit for Alcoholism or Substance Abuse Services; or
   (c) the Member fails to materially comply with any treatment program for a period of 30 days.

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

g. Exclusions: 
   In addition to the exclusions listed in the PBB, the following are not Covered:
   (1) treatment in a halfway house;
   (2) Residential Treatment Centers used for the treatment of any condition other than Alcoholism and/or Substance Abuse;
Co-dependency treatment; sex, pastoral/spiritual, bereavement counseling; and court mandated treatment, or treatment that is a condition of parole or probation or in lieu of sentencing.

P. Nutritional Support and Nutritional Supplements

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

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

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

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

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

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

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

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

Outpatient medical services include reasonable Hospital services provided on an ambulatory basis, and those preventive, Medically Necessary, and diagnostic and treatment procedures that are prescribed by the Member's Primary Care or Attending Physician, subject to the Benefit Certification requirements listed in Section VI. (Benefit Certification), the limitations listed in Section VII. (Limitations) and the exclusions listed in Section VIII. (Exclusions) of this PBB. Such services may be provided in a Hospital, Physician’s office, any other appropriate licensed facility, or any other appropriate facility if the professional delivering the service is licensed to practice, is certified, and is practicing as authorized by applicable law or authority, a medical group, an independent practice association or other authority authorized by applicable New Mexico Law. Outpatient services provided by non-Participating Providers/Practitioners are not Covered except as provided in Section IV. (General Information) item F. (Participating and non-Participating Providers/Practitioners), item K. (Dependent Students), and Section V. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Healthcare/Observation/Trauma Services).

1. Anesthetics, oxygen, drugs, medications.
2. **Blood**, blood plasma and blood components.

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

4. **Diagnostic Services**, as specified in Section V. (Benefits) 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, recovery and treatment rooms and equipment.

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

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

9. **Sleep disorder studies**.

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

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

**R. Physician Services**

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

1. a licensed Physician,

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

3. a medical group,

4. an independent practice association, or

5. other authority authorized by applicable New Mexico Law.

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

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

   "Telephone visits by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient is not Covered. Also "get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided is not Covered.

2. Home Visits, if Medically Necessary.

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

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

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

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

7. Family planning/Infertility services:
   a. FDA approved Contraceptive devices and prescription drugs excluding Over-The-Counter (OTC) items, unless listed as a Covered OTC medication on the Preferred Drug Listing, and investigational devices/medications.
   b. Sterilization procedures. Reversals of voluntary sterilization are not Covered.
   c. Infertility diagnosis and treatment, including drugs and injections administered in the Physician’s office and approved by PHP in accordance with accepted medical practice for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery. Artificial insemination is Covered for up to three inseminations. Donor sperm is not Covered. In-vitro, GIFT and ZIFT fertilization are not Covered. Reversal of voluntary sterilization is not Covered.
   d. Elective abortions as identified in item Y. Women’s Healthcare of this Section.

8. **Student Health Centers**: Dependent Students attending school either in the PHP Service Area or outside of the PHP Service Area may receive care through their Primary Care Physician or at the Student Health Center. A Benefit Certification from PHP is not needed prior to receiving care from the Student Health Center. Services provided outside of the Student Health Center are limited to Medically Necessary Covered services for the initial care or treatment of an Emergency Health Service or Urgent Care situation.
9. **Second medical opinions** by a participating specialist or Primary Care Physician (PCP). The office visit Copayment will not apply if PHP requires a second opinion to evaluate the medical appropriateness of a diagnosis or service. The office visit Copayment will apply when the Member or the Provider/Practitioner requests the second opinion.

10. **Video Visits** provided online between a designated Practitioner/provider and patient about non-urgent healthcare matters.

**S. Prescription Drug Benefit (Outpatient)**

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

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

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

- a. Tablets/Capsules, Packets: one Copayment per 30-day supply up to the maximum dosing recommended by the manufacturer;
- b. Liquids: one Copayment per 30-day supply 30-day supply up to the maximum dosing recommended by the manufacturer;
- c. Ointments, creams and lotions: one Copayment per 30-day supply 30-day supply up to the maximum dosing recommended by the manufacturer; and
- d. Specialty Pharmaceuticals: For Specialty Pharmaceuticals obtained through a designated specialty pharmacy vendor a percentage Copayment up to a maximum of dollar amount per injection/prescription is required, except when administered in an in-patient Hospital setting if Medically Necessary. Refer to your Schedule of Benefits for these percentage and dollar amount limits. These products may require Benefit Certification.

Specialty Pharmaceuticals include, but are not limited to, growth hormones, low molecular weight heparins, interferons, immunologic agents and anti-tumor necrosis factors. A copy of this listing is available on our website at [www.phs.org](http://www.phs.org) or by calling our Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219. Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407. You may also visit our website at [www.phs.org](http://www.phs.org).

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

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic (Preferred)</td>
<td>3 x generic Copayment</td>
</tr>
<tr>
<td>Brand (Preferred)</td>
<td>3 x brand Copayment</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>3 x Non-Preferred Copayment</td>
</tr>
</tbody>
</table>

4. **Mail Order Pharmacy**

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic (Preferred)</td>
<td>2 x generic Copayment</td>
</tr>
<tr>
<td>Brand (Preferred)</td>
<td>2.5 x brand Copayment</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>3 x Non-Preferred Copayment</td>
</tr>
</tbody>
</table>

5. **Over-The-Counter (OTC) medications**

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

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

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

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

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

a. patient’s name and ID number;
b. name and quantity of the drug;
c. date purchased;
d. name and phone number of Physician;
e. name and phone number of pharmacy;
f. reason for the purchase (nature of emergency); and
g. proof of payment.

8. Exclusions related to Prescription Drugs:

a. Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained.
b. Prescriptions ordered by a non-Participating Provider/Practitioner or purchased at a non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area.
c. Over-The-Counter medications and drugs for which there is a non-prescription equivalent available with the exception of approved OTC medications as determined by PHP’s Pharmacy and Therapeutics Committee. Refer to the PHP Preferred Drug Listing for a list of Covered OTC medications.
d. Compound Prescription Drugs.
e. Replacement prescriptions resulting from loss, theft, or destruction.
f. Prescription Drugs (as listed as Covered in the Schedule of Benefits and this PBB) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available.
g. Drugs, medicines, treatments, procedures, or devices that PHP determines are Experimental or Investigational.
h. Disposable medical supplies, except when provided in a Hospital or a Physician’s office or by a home health professional.
i. Treatments and medications for the purpose of weight reduction or control except for Medically Necessary treatment for morbid obesity.
j. Nutritional supplements unless for prenatal care as prescribed by the attending Physician or as sole source of nutrition. Infant formula is not Covered under any circumstance.
k. Medications used for the treatment of sexual dysfunction.
l. Medications used for cosmetic purposes.
m. New medications for which the determination of criteria for Coverage has not yet been established by PHP’s Pharmacy and Therapeutics Committee.

T. Reconstructive Surgery

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

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

U. Rehabilitation and Therapy

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

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

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

   a. Outpatient physical and occupational therapy requires that the Primary Care Physician
   or other appropriate treating Physician must determine in advance that Rehabilitation
   Services can be expected to result in Significant Improvement in the Member's condition
   within a period of two months. Treatment goals must be established at the initial visit.
   These goals must define the expected Significant Improvement. A licensed physical or
   occupational therapist must provide and/or direct therapy treatments. Treatments by a
   physical or occupational therapy technician must be performed under the direct
   supervision and in the presence of a licensed physical or occupational therapist.
   Treatments delivered by athletic trainers are not Covered.

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

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

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

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

   a. the Member has reached maximum rehabilitation potential;
   b. has reached a point where Significant Improvement is unlikely to occur; or
   c. has had therapy for four consecutive months.

   Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief.

   Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down’s Syndrome, Cerebral Palsy, and Developmental Delays not associated with a defined event of illness or injury.

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

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

   a. The Primary Care Physician or other appropriate treating Physician must determine in advance, in consultation with PHP, that speech therapy can be expected to result in Significant Improvement in the Member's condition within a period of two months.
   b. Following the initial two months of treatment, in-patient or outpatient speech therapy may be extended for a period not to exceed two additional two-month periods when:
      (1) Certified by PHP; and
      (2) the referring Physician in consultation with PHP certifies that the speech therapy is Medically Necessary and will result in Significant Improvement. For purposes of Certifying speech therapy beyond the initial two months, the determination of Significant Improvement will be established if the Member has met all therapy goals for the preceding two months as documented in the therapy record.
   c. 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.
   d. **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.

   e. Therapy for stuttering is not Covered.
   
   f. 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).
   
   g. No additional benefits are available for speech therapy.
   
   h. Under this specific HMO plan, this benefit does not renew at the beginning of a new
      Calendar Year.

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

V. Skilled Nursing Facility Care

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

W. Smoking Cessation

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

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

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

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

4. **Pharmacotherapy Benefits are limited to:**
   a. Prescription Drugs purchased at a Participating Pharmacy.
   b. two 90-day courses of treatment per Calendar Year.
   c. Refer to “Covered Medications” in your Schedule of Benefits for Copayment amounts.

5. **Exclusions:**
   a. Hypnotherapy (The use of therapeutic techniques or principals in conjunction with hypnosis. Hypnosis is the process by which a trained therapist helps the patient become so relaxed that he/she may be able to accept new ways of thinking or reacting to behaviors which the patient wishes to change.)
   b. Over-The-Counter (OTC) drugs, unless listed as a Covered OTC medication on the Preferred Drug Listing.
   c. Acupuncture for Smoking Cessation Counseling is not Covered under the Smoking Cessation Counseling Benefit. Refer to item F. (Complementary Therapies) of this section for Benefits available under the Acupuncture Benefit.

X. **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 PHP and be Certified by PHP.

4. All Organ transplants must also be deemed Medically Necessary by the Member’s Participating Physician. Transplant services shall be performed at a site approved by PHP.

5. Limited travel benefits reasonable travel and living expenses for patients and a family member are covered up to a maximum of $150 per day up to a $10,000 limit (lifetime) for travel related expenses related to the Transplant or other in-network services deemed appropriate and approved by Presbyterian Health Plan.

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

Y. Women’s Healthcare

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

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

2. Maternity and newborn care

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

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

   b. Newborn children of an employee or an employee’s spouse. You must submit an Application for your child as a Dependent through the Intel Health Benefits Center (877) GoMyBen (455-9236) within 30 days of birth. If enrolled within 30 days of birth, the baby is then covered from the moment of birth. No pre-existing condition limitation applies.

   c. Newborn children of an employee’s covered dependent child(ren). Charges for children born to covered dependent female children of Intel employees are not covered, except for those costs associated with giving birth and the routine well care of the newborn before discharge from the hospital. Charges incurred for a sick baby while in the hospital or when discharged are not covered.

   d. Neonatal care is available for the newborn child of an employee or employee’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.

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

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

4. Midwives: Midwifery is the provision of women’s healthcare management in the antepartum, intrapartum, postpartum, and interconceptual periods and infants up to six weeks of age.

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

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

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

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

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

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

5. **Prenatal Maternity Care** benefits which include prenatal care, pregnancy related diagnostic tests (including an alpha-fetoprotein IV screening test for women, generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus), visits to an Obstetrician, Certified Nurse Midwife, or Licensed Midwife, Medically Necessary nutritional supplements as determined by the attending Physician, childbirth in a Hospital or in a licensed birthing center. Elective Home Births are not Covered.

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

7. **Cytologic Screening (PAP Smear), Human Papillomavirus (HPV) screenings.** HPV Vaccine coverage for females nine (9) to 14 years of age and other populations in accordance with guidelines established by the Committee on Immunization Practices (ACIP), and mammography Coverage described in Section V. (Benefits) item E. 9 and E. 10.

8. **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 Physician and patient determine that a shorter period of Hospital stay is appropriate.

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

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

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

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

Z. **Out-of-State Training/Travel**

In most cases, only urgent or emergency services are covered when provided by an out-of-state provider. However, if you are required by the Intel Corp to be outside of New Mexico (but within the United States), all covered services (listed in this section) may also be covered if provided by an out-of-state MultiPlan/Private Healthcare Services (MP/PHCS) provider.

The Presbyterian Health Plan partnered with MultiPlan, Inc, to provide covered services from an out-of-state MP/PHCS provider. If you obtain covered services from an out-of-state MP/PHSC provider, you will be responsible for the same copay as you would have paid if you obtained the services from a PHP participating provider (in New Mexico). Additionally, you should not be balance billed any differences between what is billed by the out-of-state MP/PHCS provider and the total amount paid by PHP. If you obtain covered services from an out-of-state MP/PHCS provider, the MP/PHCS provider will bill PHP for the covered services provided, you will not have to submit a claim for reimbursement.

However, if the covered services require Benefit Certification when provided by a PHP participating provider, you will be required to contact the PHP Health Services Department at **1-888-275-7737** and obtain Benefit Certification prior to obtaining routine covered services from a MP/PHCS provider. If you do not obtain a Benefit Certification when required, benefits may be denied. If you are not sure if a covered service requires Benefit Certification, please contact our Customer Service Center at **(505) 923-5678** or toll-free at **1-800-356-2219**, Monday through Friday 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407. You may also contact a PHP Customer Service Representative by e-mail at info@phs.org.

AA. **Limited Travel Benefits**
Reason travel and living expenses for patients and family member are covered up to maximum of $150 per day up to a $10,000 limit (lifetime) for travel related expenses related to the Transplant or other in-network services deemed appropriate and approved by Presbyterian Health Plan.
VI. BENEFIT CERTIFICATION

A. What is Required?

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

B. Who is Responsible?

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

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

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

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

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

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

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

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

C. What Services and Supplies Require Benefit Certification?

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

1. blood glucose specialized monitors/meters, including those for the legally blind;
2. bone growth stimulators;
3. Cancer Clinical Trials (Investigational/Experimental) as specified in Section V. (Benefits) item D. (Cancer Clinical Trials) of this PBB.
4. Computed Axial Tomography (CAT) Scans;
5. Durable Medical Equipment;
6. foot Orthotics, as specified in Section V. (Benefits) item J. (Durable Medical Equipment) of this PBB;
7. home health services/home health intravenous drugs;
8. Hospice care;
9. Hospital admissions, Inpatient non-emergent
10. injectable drugs, (includes Purified Biological Products, Specialty Medications and home health intravenous drugs) except as noted in Section V. (Benefits) item S. (Prescription Drug Benefit (4-Tier) (Outpatient) of this PBB;
11. insulin pumps;
12. medical detoxification
13. Magnetic Resonance Imaging (MRI);
14. Mental health Inpatient services;
15. Organ transplants;
16. Orthotics;
17. out-of-plan services, excluding emergency or Urgent Care as described in this PBB;
18. PET (Positron Emission Tomography) Scans;
19. Prescription Drugs: Refer to Section V. (Benefits) item S. (Prescription Drug Benefit (4-Tier) (Outpatient) of this PBB;
20. Prosthetics;
21. reconstructive and potentially cosmetic procedures;
22. Skilled Nursing Facility care;
23. special Inpatient services, for example, private room and board and special duty nursing;
24. Substance Abuse services;
25. uterine monitoring, home.

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

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

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

C. **Organ Transplants.** Organ transplants are limited to those procedures and benefits described in Section V. (Benefits) item X. (Transplants).

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

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

F. **Coverage while away from the Service Area.** When a Member is away from the Service Area, **Coverage is limited to Emergency Health Services and Urgent Care** except as outlined in Section V. (Benefits), item Z. (Out-of-State Training/Travel). This limitation may not apply to Dependent children enrolled under the provisions of Section IX. (Eligibility, Enrollment and Effective Dates) item A. (Who is Eligible?).
VIII. EXCLUSIONS

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

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

C. Alternative/complementary therapies, except as specified in Section V. (Benefits) item F. (Complementary Therapies) of this Presbyterian Benefit Booklet (“PBB”).

D. Artificial aids including speech synthesis devices (except items identified as being Covered in Section V. (Benefits) item J. (Durable Medical Equipment) of this PBB.

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. Halfway houses.
   2. Residential Treatment Centers unless for the treatment of Alcoholism and/or Substance Abuse.
   4. Counseling: sex, pastoral/spiritual, and bereavement counseling.
   5. Psychological testing when not Medically Necessary.
   6. Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies to whether or not associated with manifest mental illness or other disturbances.

I. Benefits and services not specified as Covered.

J. Biofeedback, except as specified in Section V. (Benefits) item F. (Complementary Therapies) of this PBB.

K. Exclusions relating to Cancer Clinical Trials:
   1. Any Cancer Clinical Trials provided outside of New Mexico as well as those, that do not meet the requirements listed in Section V. (Benefits) item D. (Cancer Clinical Trials).
2. Costs of the Clinical Trial that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S. Corrective eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, except as identified in Section V. (Benefits) item J. (Durable Medical Equipment) of this PBB.
T. Cosmetic Surgery. Examples of Cosmetic Surgery include, but are not limited to, breast augmentation, dermabrasion, dermplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.

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

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

W. Custodial or Domiciliary Care.

X. Exclusions relating to dental services:
   1. Dental care and dental x-rays, except as provided in Section V. (Benefits) 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 Presbyterian Health Plan.
   2. Dental implants.
   3. Malocclusion treatment, if part of orthodontics and routine dental care.
   4. Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.

Y. Exclusions related to Durable Medical Equipment (DME):
   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 PHP), Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
   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 loss, neglect, misuse, abuse, to improve appearance or convenience.
   7. Repair and replacement of items under the manufacturer or supplier’s warranty.

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

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

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

1. the drug, medicine or device cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (“FDA”) and approval for marketing has not been given at the time the drug, medicine or device is furnished;
2. the FDA has determined that use of the drug, medicine or device is contraindicated for the particular indication for which it has been prescribed;
3. reliable evidence shows that the drug, medicine, and/or device, treatment, or procedure is the subject of ongoing Clinical Trials, except as specified in Section V. (Benefits) 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.

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

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

1. Food substitutes for lactose intolerance including soy foods or formulas or other Over-The-Counter (OTC) digestive aids, unless listed as a Covered OTC medication on the Preferred Drug Listing,
2. Organic foods,
3. Ordinary foodstuffs that might be part of an exclusionary diet,
4. Food substitutes that do not qualify as Special Medical Foods,
5. Any product that does not require a Physician’s prescription,
6. Special Medical Foods for conditions that are not present at birth,
7. Food items purchased at a health food, vitamin or similar store,
8. Foods purchased on the Internet, and
9. Special Medical Foods for conditions including, but not limited to: Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, and Allergies to food products.

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

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

AH. Hearing aids and the evaluation for the fitting of hearing aids except for school aged children under 18 years old (or under 21 years of age if still attending high school).

AI. Hospice benefits are not Covered for the following services:
   1. food, housing, and delivered meals;
   2. volunteer services;
   3. comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits);
   4. homemaker and housekeeping services;
   5. private duty nursing;
   6. pastoral and spiritual counseling; and
   7. bereavement counseling.

AJ. Hypnotherapy except as part of an anesthesia preparation or chronic pain management.

AK. The following Infertility Services/Artificial conception services are not Covered: 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. Services of a lay Midwife or an unlicensed Midwife.

AN. Charges for children born to covered dependent female children of Intel employees are not covered, except for those costs associated with giving birth and the routine well care of the newborn before discharge from the hospital. Charges incurred for a sick baby while in the hospital or when discharged are not covered.

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

AP. Non-human Organ transplants except for porcine (pig) heart valve.
AQ. Covered services obtained from a **non-Participating Provider/Practitioner**, except for the following:

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

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

AR. **Nutritional supplements** except as described in Section V. (Benefits) item S. (Prescription Drug Benefit (4-Tier) (Outpatient).

AS. 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.

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

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

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

AW. **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.

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

1. Compound Prescriptions.

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

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

4. Outpatient Prescription Drugs, except as described in Section V. (Benefits) item S. (Prescription Drug Benefit (4-Tier) (Outpatient) of this PBB. Unless listed as Covered in your Schedule of Benefits refer to Section V. (Benefits) item S. (Prescription Drugs (4-Tier) (Outpatient).

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

6. Prescription Drugs (as listed as Covered in your Schedule of Benefits) received upon

---

INTEL HMO  

64  

Eff. 1/1/15
Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient Pharmacy is not available.

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

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

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 employee 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 employee or Dependent.

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

AAD. Sex transformation surgery and drugs relating to sex transformation.

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

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 or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient. Also "get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided.

AAH. Transportation costs for deceased Members.

AAI. Travel and lodging expenses except as provided in Section V. (Benefits) item AA. Limited Travel of this PBB.

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 Refractions for determining prescriptions for corrective
lenses, except as identified in Section V. (Benefits) item J. (Durable Medical Equipment) of this PBB.


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

AAL. Costs for extended warranties and premiums for other insurance Coverage.

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

AAN. Treatment of work-related accidents or injuries or occupational illness or disease if the Member is required to be Covered under workers’ compensation insurance, whether or not such Coverage actually exists.
IX. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Refer to Intel’s Pay, Stock & Benefits Handbook for eligibility, enrollment and effective date information. To access the Pay, Stock & Benefits Handbook, go to Circuit or call the Intel Health Benefits Center (877) GoMyBen (466-9236).
X. CLAIMS

A. Participating Providers/Practitioners

Presbyterian Health Plan (PHP) pays Participating Providers/Practitioners directly for Covered services provided to Members. A Member should not be required to pay sums to any Participating Provider/Practitioner except for required Copayments and Co-insurance, if applicable. Members will be responsible for payment of charges for missed appointments or appointments canceled without adequate notice. If a Member is asked by a Primary Care Physician to make any Copayments in addition to those Copayments specified in this PBB, the Member should consult our Customer Service Center before making any such additional Copayments. A Member shall not be liable to a Participating Provider/Practitioner for any sums owed to the Provider/Practitioner by PHP.

B. Non-Participating Provider/Practitioner – Benefit Certification

Except for Emergency Health Services described in Section V. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Healthcare/Observation/Trauma Services); a Member must receive written Benefit Certification from PHP prior to receiving services from a non-Participating Provider/Practitioner. Otherwise, the Member will be responsible for all charges incurred.

Members who receive Certified benefits from an approved non-Participating Provider/Practitioner may be required to make full payment to that Provider/Practitioner at the time services are rendered. The Member should then submit satisfactory evidence to PHP that such payment was made to a non-Participating Provider/Practitioner. Upon review and approval of the Member's evidence of payment, PHP shall reimburse the Member for Covered Benefits, based upon Reasonable and Customary Charges, less any required Copayment the Member would have been required to pay if the services had been obtained from a Participating Provider/Practitioner. The Member will be responsible for charges not specifically Covered by this HMO plan. Emergency Health Services rendered to a Member while traveling outside of PHP's Service Area shall be Covered as specified in Section V. (Benefits) item A. (Accidental Injury /Urgent Care /Emergency Healthcare/ Observation/Trauma Services) of this PBB. Member's relying on a non-Participating Provider/Practitioner to file a claim on their behalf are responsible for ensuring claims have been submitted within one year from the date of service. Any such charge shall be paid only upon receipt of written proof satisfactory to PHP of the occurrence, character and extent of the event and services for which claim is made.

C. Procedure for Reimbursement

If a charge is made to a Member for Covered Benefits, written proof of such charge must be furnished to PHP within 90 days after performance of the service to receive reimbursement. Any such charge shall be paid only upon receipt of written proof satisfactory to PHP of the occurrence, character and extent of the event and services for which claim is made.
If you need a claim form please contact the PHP Customer Service Center. Claim forms are also available on our website at [www.phs.org](http://www.phs.org). Please submit your completed claim form to:

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

D. **Services Received Outside the United States**

Benefits are available for emergent and urgent services received outside the United States. These services are Covered as explained in Section V. (Benefits) item A. (Accidental Injury/Urgent Care/Emergency Healthcare/Observation/Trauma Services) of this PBB. 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.

E. **Fraud**

Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. PHP may terminate a Member for any type of fraudulent activity. For further information regarding Fraud please refer to Section IV. (General Information) item U. (Fraud).
XI. EFFECTS OF OTHER 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 HMO plan and any other plan covering a Member not on COBRA continuation on whose behalf a claim is made are as follows:
   a. Employee/Dependent Rule
      (1) The plan which Covers the Member as an employee pays first; and
      (2) The plan, which Covers the Member as a Dependent, pays second.
   b. Birthday Rule for Dependent children of parents NOT separated or divorced.
      (1) The plan, which Covers the parent whose birthday falls earlier in the year, pays first. The plan, which Covers the parent whose birthday falls later in the year, pays second. The birthday order is determined by the month and the day of birth, not the year of birth.
      (2) If both parents have the same month and day of birth, the plan that Covered the parent longer, will pay claims first. The plan, which Covered the parent for a shorter period of time, pays second.
   c. Dependent children of separated or divorced parents.
      (1) The plan of the parent decreed by a court of law to have responsibility for medical Coverage pays first.
      (2) In the absence of a court order:
         (a) the plan of the parent with physical custody of the child pays first;
         (b) the plan of the spouse of the parent with physical custody (i.e., the stepparent) pays second; and
         (c) the plan of the parent not having physical custody of the child pays third.
   d. Active/Inactive.
      (1) The plan which Covers the Member as an active employee (or Dependent of an active employee) pays first; and
      (2) The plan, which Covers the Member as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.
   e. Longer/Shorter. In the case of a Member who is the Contract holder under more than one Group health insurance policy, then the plan that has Covered the Member for a longer period of time will pay first. The start of a new plan does not include a change of insurance carrier by the employer.
   f. No Coordination Provision. In spite of rules a, b, c, d, or e, the plan that has no provision regarding coordination of benefits will pay first.

3. In no event shall the benefits received under this HMO plan and all other plans combined exceed the total reasonable actual expenses for the services provided under this HMO plan.
4. For purposes of coordination of benefits, PHP
   a. may release, request, or obtain claim information from any individual or organization. In addition, any Member claiming benefits from PHP shall furnish PHP with any information which it may require; and
   b. has the right, if overpayment is made by PHP because of the Member's failure to report other Coverage or any other reason, to recover such excess payment from any individual to whom, or for whom, such payments were made; and
   c. will not be obligated to pay for Non-Covered services or Covered Benefits not obtained in compliance with PHP's policies and procedures.

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

B. Medicare
   The benefits under this HMO plan for Members enrolled in Medicare are not designed to duplicate any benefit to which the Member is entitled under the Social Security Act. Benefits will be coordinated in compliance with current applicable federal regulations.

C. Medicaid
   Benefits payable by PHP on behalf of an Enrollee who is qualified for Medicaid will be paid to the state Human Services Department, or its designee, when:
   1. the Human Services Department has paid or is paying benefits on behalf of the Enrollee under the state's Medicaid program pursuant to Title XIX and/or XXI of the Federal Social Security Act; and
   2. the payment for the services in question has been made by the state Human Services Department to the Medicaid Provider/Practitioner.

D. Third-Party Responsibility for Medical Expenses
   You, individually and on behalf of your enrolled family member(s), as a condition of receiving any benefits, agree that if a health plan sponsored by Intel Corporation provides health services that are the result of any act or omission of any other party, the following will apply:
   1. The plan shall have all the rights that you or your family member(s) have to recover against any person or organization, to the full extent of all the benefits provided by the plan and any other amounts it is entitled to. The plan may, within its sole discretion, take action to preserve its rights, including filing a suit in your name.
   2. You and your family member(s) assign to the plan an amount equal to the benefits paid by the plan against any recovery you or your family member(s) are entitled to receive. The plan is also granted a lien on any such recovery.
3. The plan’s rights extend to any sources of recovery, including, but not limited to, payments from any uninsured, underinsured, no-fault, or any other motorist or other insurance coverage, or any Workers' Compensation award or settlement, or any other type of payments from a third party. The plan’s right to recover shall also apply to settlements or recoveries with respect to a decedent, minor, and incompetent or disabled person.

4. You or your family member(s) shall not do anything to prejudice the plan’s right to recover, including making any settlement that reduces or excludes the benefits provided by the plan. In addition, the plan shall be entitled to recover reasonable attorneys’ fees incurred in collecting any recovery proceeds held by you or your family members.

5. The plan has the right to recover the full amount of benefits provided without regard to any of the following: any fault on the part of you or your family member(s); any attorneys fees or costs incurred by or on behalf of you or your family member(s); or whether or not you or your family member(s) have been fully compensated for all injuries or conditions.

6. Any failure to follow these or other terms of the plan would cause irreparable and substantial harm, for which no adequate remedy at law would exist, and the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien or constructive trust, as well as injunctive relief.

7. Within its sole discretion, the plan has the right to reduce the amount it seeks to recover for the benefits it has paid to you or your family member(s). Any such decision shall not waive the plan’s right to full reimbursement at any other time, or grant you or your family member(s), or any other party, any right to such reduction.
XII. COMPLAINTS, GRIEVANCES AND APPEALS

Overview
Many Grievances or problems can be handled informally by calling the PHP’s Consumer Assistance Office at (505) 923-5678 or toll-free at 1-800-356-2219 or TTY/TDD (505) 923-5699, TTY/TDD toll-free (877) 298-7407 or visit our website at www.phs.org.

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

If your Grievance concerns a decision by PHP to deny, reduce or terminate a requested healthcare service on the grounds that it is either not a Covered Benefit or it is not Medically Necessary, the Grievance will be subject to the adverse determination Grievance review procedure. See “A” in this section.

Administrative Grievances: If your Grievance concerns any other action or inaction by PHP concerning any other aspect of PHP’s health benefits plan, other than the request for healthcare services, including but not limited to administrative practices of the healthcare insurer that affect the availability or delivery of healthcare services, claims payment, handling or reimbursement for healthcare services and terminations of Coverage, then the Grievance will be subject to the administrative Grievance review procedure. See “B” in this section.

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

You may request a copy and detailed written explanation of the Grievance procedures by calling the Presbyterian Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407. You may also download some of the Grievance forms from our website at www.phs.org

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

A. Adverse Determination Grievance Review Procedures

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

Presbyterian Health Plan  
Grievance Department  
2501 Buena Vista Drive SE  
Albuquerque, NM 87106  
(505) 923-5644 or toll-free at 1-800-356-2219  
FAX (505) 923-5124  
E-mail: gappeals@phs.org

PHP’s internal adverse determination Appeal review procedures require an initial review by a PHP medical director and then, if necessary, a second review by a medical panel. Both reviews must be completed within 72 hours when the circumstances require expedited review or within 20 working days for all other cases. If PHP’s medical director decides to uphold the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the medical director’s decision by telephone and mail and will ask you whether you want a second review by a medical panel selected by the healthcare insurer.

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

B. Administrative Grievance Procedures

If you are dissatisfied with a decision, action or inaction of PHP regarding a matter that does not involve the denial, reduction or termination of a requested health service, then you have the right to request, orally or in writing, that PHP internally review the matter. First, a PHP representative will review the Grievance and provide you with a written decision within 15 working days from receipt of the Grievance.

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

C. External Review of a Denied Appeal

If your appeal is denied, you may submit a request for external review within 4 months of the date of your appeal denial letter. Instructions on how to request an external review are included on the denial notice from Presbyterian Health Plan. External reviews are conducted by an Independent Review Organization (IRO).

Denials of urgent care claims are eligible for expedited external review by an IRO.

Please review the Intel Pay Stock and Benefits Handbook for additional information or contact the Presbyterian Health Plan Grievance Department at (505) 923-5644 or toll-free at 1-800-356-2219 directly with questions.
If you choose to file a voluntary appeal with MRI:

- You may do so only after exhaustion of the required appeal to your health plan. Accordingly, you must first submit an appeal with your health plan, and receive a denial of your appeal before requesting a voluntary appeal.
- After you receive a denial of your appeal, you must submit the request for a voluntary appeal with your health plan in writing within 60 calendar days from the date of the appeal denial letter from your health plan.
- The health plan will forward a copy of the final appeal denial letter and all other pertinent information that was reviewed in the appeal to MRI. You may also submit additional information you wish to be considered.
- MRI is an external review organization that utilizes independent physicians with appropriate expertise to perform the review of voluntary appeals. In rendering a decision, MRI may consider any appropriate additional information submitted by you and will follow the plan documents governing your benefits.
- You will be notified of the decision of MRI within 30 days of the receipt of the request for the voluntary appeal.
- The statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending.

If you choose not to submit a voluntary appeal:

- The Intel Corporation Health and Welfare Plan waives any right to assert that you have failed to exhaust administrative remedies.

D. Retaliatory Action

PHP cannot take retaliatory action against you for filing a Grievance under this health benefits plan.
XIII. RECORDS

A. Creation of Non-Medical Records

PHP shall keep Member records related to identification information, which does not specifically relate to the Member’s medical diagnosis or treatment. The individual Member and/or Intel Corporation shall forward information periodically as may be required by PHP in connection with the administration of this.

B. Accuracy of Information

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

C. Consent for Use and Disclosure of Medical Records

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

D. Professional Review

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

E. Confidentiality of Protected Health Information/Medical Records

Each Member will receive a Notice of Privacy Practices that PHP issues, which will contain a statement of the Members’ rights with respect to, Protected Health Information and a brief description of how the Member may exercise their rights.
1. **What is Protected Health Information?**

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

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

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

a. request restrictions on certain uses and disclosures of PHI, although PHP is not required to agree to a requested restriction;

b. receive confidential communications of PHI from PHP;

c. with certain exceptions, inspect and receive a copy of PHI;

d. request an amendment to PHI you believe to be incorrect or incomplete;

e. receive an accounting of certain disclosures of PHI; and

f. obtain a paper copy of the Notice of Privacy Practices from PHP upon request (even if the Member previously agreed to receive the Notice(s) electronically).

2. **Access to PHI**

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

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

a. Psychotherapy Notes; or

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

c. PHI maintained by PHP that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 U.S.C. 263a, to the extent the provision of access to the Member would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988 (CLIA), pursuant to 42 CFR 493.3(a)(2).

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

Presbyterian Health Plan  
Attn: Director, Customer Service Center  
P.O. Box 27489  
Albuquerque, NM 87125-7489
PHP will act on your request for access to PHI no later than 30 days after receipt of the request. If PHP is unable to take an action within the required timeframe, the plan may take up to 30 additional days, provided that, no later than 30 days after receiving your request the plan provides you with a written statement of the reason for the delay and date by which PHP will complete its action on your request.

3. Routine Uses and Disclosures of PHI

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

a. claims payment;
b. fraud and abuse prevention;
c. data collection;
d. performance measurements;
e. meeting state and federal requirements;
f. utilization management;
g. accreditation activities;
h. preventive health services;
i. early detection and disease management programs; coordination of care; quality assessment and measurement, including surveys of Members; research of Complaints and Grievances; billing; and other stated uses; and
j. responding to Member requests for information, products or services.

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

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

4. Consents/Authorizations

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

In the event that the Provider/Practitioner fails to obtain such consent for disclosure to PHP, or you refuse to sign such consent for disclosure to PHP, PHP shall use its best efforts to obtain such written consent from you (or Member’s legal guardian/Personal Representative) prior to the Provider’s/Practitioner’s release of PHI (i.e. health records) to PHP for purposes permitted by law.
When you sign your enrollment form, you are giving consent (to the extent permitted by applicable law) to the use or the release of your PHI by any person or entity including without limitation, Providers/Practitioners and insurance companies to PHP or its designees (including its authorized agents, regulatory agencies and affiliates) for any permitted purpose, including but not limited to, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the payment or certain healthcare operations activities of PHP. This consent does not permit a use or disclosure of PHI when an authorization is required by law.

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

We require all Participating Providers/Practitioners and facilities to maintain confidential patient information in accordance with federal and state laws including, HIV/AIDS status, mental health, sexually transmitted diseases or alcohol/drug abuse. State and federal law prohibits further disclosure of HIV/AIDS, other sexually transmitted disease, mental health and alcohol abuse and drug abuse information to any person or agency without obtaining specific valid written authorization for that purpose from the patient (or legal guardian/Personal Representative), or as otherwise permitted by state or federal law.

To request an Authorization Form, please contact our Customer Service Center. 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 healthcare decisions for a child or other person (for example, a parent or legal guardian) can exercise the health information rights described herein for the child or other person, but not always. Unless otherwise required or permitted by law, when we need an Authorization Form signed for a person who can’t make healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

6. **Right to Request Amendments (Changes) to PHI**

PHP recognizes your right to request amendment of PHI or a record containing PHI for as long as the PHI is maintained in our records. Presbyterian’s Customer Service Center will accept written requests to amend PHI. PHP must approve or deny your request to amend the disputed PHI no later than 60 days after receipt of the request. If PHP is unable to take an action within the required timeframe, the HMO plan may take up to 30 additional days, provided that, no later than 60 days after receiving your request, the HMO plan provides you with a written statement of the reason for the delay and date by which PHP will complete its action on your request and notify you in writing of the determination no later than 60-90 days after receipt of such a request.
7. **Process for Members to Request an Accounting of Disclosures of PHI**

You (or Members legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Customer Service Center. With some exceptions, as described in the Notice of Privacy Practices issued by PHP the accounting will show when PHP disclosed PHI about you to others without authorization from you.

8. **Restriction of PHI use or Disclosures:**

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

a. PHP’s Treatment, Payment and Healthcare Operations; and
b. to persons involved in your care (e.g., family member, other relative, close personal friend, or any other person identified by the Member); and
c. for notification purposes of your location, general condition, or death; and
d. to a public or private Entity authorized by law or its charter to assist in disaster relief efforts.

PHP is not required by law to agree to any requested restriction. If PHP does agree to honor a requested restriction, PHP will not violate such restriction, except as permitted by law. PHP will accept your written request to restrict the use or disclosure of your PHI, or will document your verbal request in our records.

9. **Use of Measurement Data**

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

10. **Internal Protection of Oral, Written and Electronic PHI Across PHP**

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

a. PHI is accessed by plan personnel only if such information is necessary to the performance of job related tasks.
b. PHI is not discussed inside or outside the facility, unless the data is necessary to the performance of job related tasks.
c. PHI, reports and other written materials are reasonably safeguarded throughout the facility against unauthorized access by plan personnel or public viewing.
d. All employees, volunteers, and any external entity with a business relationship with PHP that involves health information will be held responsible for the proper handling of PHP’s data and business communications and are required to sign a confidentiality statement or business associate agreement, respectively.
Violation of the above rules by any member of PHP’s workforce is grounds for disciplinary action, up to and including immediate dismissal.

11. Web Site Internet Information

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

a. Website traffic statistics, including:
   (1) Where visitor traffic comes from
   (2) How traffic flows within the website
   (3) Browser type

   We monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful.

b. Personal information you provide us (such as your name, address, billing information, health plan Member status, etc.) if you fill out a form on the PHS website.

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

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

12. Protection of Information Disclosed to Plan Sponsors, Employers or Government Agencies

PHP policies and procedures prohibit sharing your PHI with any fully insured employer Groups plan sponsor without authorization for the Member (or Member’s legal guardian/Personal Representative). PHP is careful not to release PHI to your employer as part of routine financial and operating reports. We may disclose summary health information that does not identify individual Members to plan sponsors for allowable purposes. We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards as permitted by law.

If you have any questions regarding your PHI or would like to access your health records, you can call our Customer Service Center at (505) 923-5678, toll-free 1-800-356-2219, Monday through Friday, 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.
XIV. TERMINATION

Refer to Intel’s Pay, Stock & Benefits Handbook for information on when you and your enrolled dependents can continue coverage under this HMO plan through COBRA coverage in the event your or they lose coverage as a result of certain qualifying events.
XV. GLOSSARY OF TERMS

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

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

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 benefit period that is the Member's responsibility.

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

APPLICATION means the form that each Subscriber is required to complete when enrolling for PHP Coverage.

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 the process whereby PHP or PHP’s delegated Provider/Practitioner contractor reviews and approves in advance the provision of certain Covered Benefits to Members before those services are rendered. If services requiring Benefit Certification are obtained from non-Participating Providers/Practitioners and Benefit Certification was not obtained, the Member will be responsible for the resulting charges. Services rendered beyond the scope of the Benefit Certification are not Covered.

CALENDAR YEAR means the period beginning January 1, and ending December 31.

CANCER CLINICAL TRIAL means a course of treatment provided to a patient for the purpose of prevention of reoccurrence, early detection or treatment of cancer that is being provided in New Mexico.
CARDIAC REHABILITATION means the improvement of functions having to do with the heart.

CERTIFIED NURSE MIDWIFE means any person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse Midwife.

CERTIFICATE OF CREDITABLE COVERAGE means a certificate given to a Member when his/her enrollment from PHP terminates and which states the period of time that the Member was Covered by PHP under a benefit plan for healthcare services. Either Intel Corporation or PHP may be responsible to prepare and deliver the certificate, in compliance with all applicable requirements of state and federal law, to the Member.

CESSATION COUNSELING means a program, including individual, group or proactive telephone quit line, that:

1. is designed to build positive behavior change practices and provides counseling at a minimum on establishment of reasons for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow-up;

2. operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education materials and method for verifying Enrollee attendance;

3. employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities; and

4. uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

CO-DEPENDENCY means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent person (DSM IV- The Diagnostic & Statistical Manual of Mental Disorders Fourth Edition Copyright 1994).

COMPLAINT means the first time PHP is made aware of an issue of dissatisfaction, not complex in nature. For more complex issues of dissatisfaction see definition for Grievance.

COPAYMENT means the amount required to be paid by a Member directly to the Provider/Practitioner in connection with healthcare services. If the charged amount for the medical or pharmacy services provided to you is less than your Copayment amount, then you pay the lesser amount.
COSMETIC SURGERY means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

COVERAGE/COVERED OR COVERED BENEFITS means benefits extended under this HMO plan, subject to the terms, conditions, limitations, and exclusions of this PBB.

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.

DEPENDENT means any Member of an employee’s family who meets the eligibility requirements as outlined in the Eligibility and Availability of Benefits section of the Intel Pay, Stock & Benefits Handbook.

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

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

ELECTIVE HOME BIRTH means a birth that was planned or intended by the Member or Provider/Practitioner to occur in the home.
EMERGENCY HEALTH SERVICES means healthcare procedures, treatments, or services delivered to a Covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

1. jeopardy to the person’s health;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily Organ or part; or
4. disfigurement to the person.

ENROLLEE means anyone who is entitled to receive healthcare benefits provided by PHP.

EXPERIMENTAL OR INVESTIGATIONAL refer to Section VIII. (Exclusions) of this PBB.

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.

FDA means the United States Food and Drug Administration.

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

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

GRIEVANCE means any expression of dissatisfaction from any Member, Provider/Practitioner or their representative.

HEARING AID means the 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 the laws of the State of New Mexico as a Home Health Agency and which has entered into an Agreement with PHP or has been approved by PHP in advance to provide Covered Benefits to PHP Members.

HOSPICE means a duly licensed facility or program, which has entered into an Agreement with PHP to provide healthcare services to Members who are diagnosed as terminally ill.
HOSPITAL means an acute care general Hospital, which:
1. has entered into an Agreement with PHP to provide Covered Hospital services to PHP Members;
2. provides Inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed Physicians;
3. is not, other than incidentally, a place for rest, a place for the aged, or a nursing home; and
4. is duly licensed to operate as an acute care general Hospital under applicable state or local law.

HUMAN PAPILLOMAVIRUS means a test approved by the Federal Food and Drug Administration for detection of the Human Papillomavirus.

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

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

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

INVESTIGATIONAL OR EXPERIMENTAL refer to Section VIII. (Exclusions) of this PBB.

LICENSED MIDWIFE means a person who has successfully completed all the requirements for New Mexico Licensed Midwifery and is in good standing with the Public Health Division. Licensed Midwives must follow midwifery protocols in accordance with the “Standards and Core Competencies of Practice for Licensed Midwives in New Mexico” and the “New Mexico Midwives Association: - Practice Guidelines.”

LIFETIME MAXIMUM means the maximum dollar amount PHP will pay for a particular benefit during the lifetime of a Member under this PBB.
LONG-TERM THERAPY OR REHABILITATION SERVICES
Therapies are considered Long-term if the Member's Physician, in consultation with PHP, does not believe Significant Improvement is likely to occur within two months. Long-Term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down’s Syndrome and Cerebral Palsy.

MAINTENANCE MEDICATIONS
means a medication taken regularly such as, on a daily or monthly basis in order to maintain the Member’s health.

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

MAMMOGRAPHY
means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic persons and includes the x-ray examination of the breast using equipment that is specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has a radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast. Screening Mammography includes the professional interpretation of the film, but does not include diagnostic mammography.

MATERNITY
means Coverage for prenatal, intrapartum, perinatal or postpartum care.

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

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

MEDICARE
means Title XVIII of the Social Security Act and all amendments thereto.

MEMBER
means the employee or Dependent eligible to receive services for Covered Benefits under this PBB.

NON-PARTICIPATING PROVIDER/PRACTITIONER
means a healthcare Provider/Practitioner, including medical facilities, who has not entered into an Agreement with PHP to provide healthcare services to PHP Members.

NUTRITIONAL SUPPORT
means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is only Covered when enteral tube feedings are required.
OBSERVATION SERVICES means outpatient services furnished by a Hospital and Provider/Practitioner on the Hospital’s premises. These services may include the use of a bed and periodic monitoring by a Hospital’s nursing staff, which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient’s condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Providers/Practitioners written order. To transition from observation to an Inpatient admission level of care criteria used by PHP must be met. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

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

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

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

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

OUT-OF-NETWORK means services obtained from a non-Participating Provider/Practitioner as defined above.

OVER-THE-COUNTER (OTC) means a drug for which a prescription is not normally needed.

PHP means Presbyterian Health Plan, Inc., a corporation organized under the laws of the State of New Mexico.

PARTICIPATING PHARMACY means any duly licensed pharmacy, which has entered into an Agreement with PHP to dispense prescribed drugs to PHP Members.

PARTICIPATING PHYSICIAN means any duly licensed Provider/Practitioner of the healing arts acting within the scope of his/her license who has entered into an Agreement directly with PHP to provide healthcare services to PHP Members.

PARTICIPATING PROVIDER/PRACTITIONER means any duly licensed individual or institutional Provider of healthcare services, which has entered into an Agreement directly with PHP to provide healthcare services to PHP Members.

PAY, STOCK & BENEFITS HANDBOOK means the Plan document and summary plan description for Intel Corporation’s Health and Welfare Plan (the Intel Group Health Plan).
PERSONAL REPRESENTATIVE means a parent, guardian, or other person with legal authority to act on behalf of an individual in making decisions related to healthcare.

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

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

PREFERRED DRUG LIST means a list of drugs approved for Coverage under this PBB and will indicate at which tier level a drug is Covered. PHP’s Pharmacy and Therapeutics Committee continually update this listing. A copy of this listing is available on our website at www.phs.org or by calling Presbyterian’s Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219 or TTY/TDD (505) 923-5699, TTY/TDD toll-free (877) 298-7407 or visit our website at www.phs.org.

PRESBYTERIAN BENEFIT BOOKLET (PBB) means this booklet, including supplements or endorsements, if any.

PRESCRIPTION DRUGS means those drugs that, by federal law, require a Physician's prescription for purchase (the original packaging of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend, "Caution: Federal law prohibits dispensing without a prescription" or is so designated by the New Mexico State Board of Pharmacy as one which may only be dispensed pursuant to a prescription).

PREVAILING RATE means the rates generally charged in PHP's Service Area for medical, surgical, Hospital and related healthcare services.

PRIMARY CARE PHYSICIAN means a healthcare Provider/Practitioner approved by PHP and formally selected by the Member who supervises, coordinates, and provides initial and basic care to Members, who initiates their referral for specialist care, and who maintains continuity of patient care. PHP designates Providers/Practitioners to be Primary Care Physicians, provided they:

1. provide care within their scope of practice as defined under the relevant state licensing law;
2. meet PHP’s eligibility criteria for healthcare Providers/Practitioners who provide Primary Care; and
3. agree to participate and to comply with PHP’s care coordination and referral policies.

Primary Care Physicians includes, but is not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). A list of Practitioners who serve as Participating Primary Care Physicians may be found in the PHP Provider Directory.

PROSTHETIC DEVICE means an artificial device to replace a missing part of the body.
PROVIDER/PRACTITIONER means any duly licensed institutional Provider of healthcare services or individual who provides services to PHP Members.

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

REASONABLE CHARGE or REASONABLE AND CUSTOMARY CHARGE means the amount determined to be payable by PHP for services rendered to Members by non-Participating Providers/Practitioners, based upon the following criteria:

1. the PHP fee schedule for the services provided;
2. fees that a professional Provider/Practitioner usually charges for a given service;
3. fees which fall within the range of usual charges for a given service filed by most professional Providers/Practitioners in the same locality who have similar training and experience; and
4. fees which are usual and customary or which could not be considered excessive in a particular case because of unusual circumstances.

RECONSTRUCTIVE SURGERY means the following:

1. surgery to correct a physical functional disorder resulting from a disease or congenital anomaly;
2. surgery to correct a physical functional disorder following an injury or incidental to any surgery; and
3. Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

REHABILITATION FACILITY means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

REMITTING AGENT means the person or entity designated by the Group to collect and remit the Prepayment to PHP.

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

SEMI-PRIVATE means a two or more bed Hospital room, Skilled Nursing Facility or other healthcare facility or program.

SERVICE AREA means the geographic area in which PHP is authorized to provide services as a Health Maintenance Organization and includes the entire state of New Mexico with the exception of southern Eddy County. The Service Area is depicted on Exhibit A. The area may be changed by PHP by written notice to the Member or Group.
SHORT-TERM REHABILITATION means rehabilitation and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected within two months from the date therapy first begins.

SIGNIFICANT IMPROVEMENT means that:

1. the patient is likely to meet all therapy goals for the first two months of therapy; or
2. the patient has met all therapy goals in the preceding two months of therapy, as specifically documented in the therapy record.

SKILLED NURSING FACILITY means an institution which is licensed under state law to provide skilled care nursing services and which has entered into an Agreement with PHP to provide Covered Benefits to PHP Members.

SMOKING CESSATION COUNSELING/PROGRAM means a program, including individual, group, or proactive telephone quit line, that:

1. is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow up;
2. operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying Enrollee attendance;
3. employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities; and
4. uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

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

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

1. Oral or inhalation forms of Specialty Pharmaceuticals (deemed Part D by Medicare) are those which can be administered on a routine basis by a patient or family member at home. Oral or inhalation forms of Specialty Pharmaceuticals are subject to the Tier 4 Copayment and may be subject to Benefit Certification.

2. Self-administered Specialty Pharmaceuticals (deemed Part D by Medicare) are defined as those which are administered more often than once a month by a patient or family member at home, are administered subcutaneously or intramuscularly and considered safe for self administration by PHP’s Pharmacy and Therapeutics Committee. Self-administered Specialty Pharmaceuticals must be obtained through a designated specialty pharmacy vendor, are subject to the Tier 4 Copayment and may be subject to Benefit Certification.

3. Intravenous (IV) Specialty Pharmaceuticals (for example, those medications administered into the vein in conjunction with a physician office visit and deemed Part B by Medicare) are not considered self-administered Specialty Pharmaceuticals. Intravenous (IV) Specialty Pharmaceuticals are not subject to the Tier 4 Copayment and may be subject to Benefit Certification.

This listing is continually updated by PHP’s Pharmacy and Therapeutics Committee. A copy of this listing is available on our website at www.phs.org or by calling Presbyterian’s Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday, 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.

STUDENT means a person attending an accredited college or university, trade or secondary school.

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

SUBSTANCE ABUSE means dependence or abuse of substances meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

TEMPOROMANDIBULAR JOINT (TMJ) is the joint that hinges the lower jaw (mandible) to the temporal bone of the skull.

TERTIARY CARE FACILITY means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

TOBACCO means cigarettes (including roll-your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, cuttas, and dhumti), pipe, smokeless Tobacco (including snuff, chewing Tobacco and bettle nut), and novel Tobacco products, such as eclipse, accord or other low-smoke cigarettes.
**TOTAL ALLOWABLE CHARGES** means, for Participating Providers/Practitioners, the Total Allowable Charges may not exceed the amount the Provider/Practitioner has agreed to accept from PHP for a service and for non-Participating Providers/Practitioners, the Total Allowable Charges may not exceed the Reasonable and Customary Charge as determined by PHP for a service.

**URGENT CARE** means Medically Necessary healthcare services provided in emergencies or after a Primary Care Physician’s normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

**URGENT CARE CENTER** means a facility operated to provide healthcare services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

**VOCATIONAL REHABILITATION** means services, which are required in order for the individual to prepare for, enter, engage in, retain or regain employment.

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

**WOMEN’S HEALTHCARE PROVIDER/PRACTITIONER** means any Participating Physician who specializes in women’s health and is recognized as a Women’s Healthcare Provider/Practitioner by PHP.

*This Presbyterian Benefit Booklet (“PBB”) is intended to be a supplement to the Intel Pay, Stock & Benefits Handbook. The Intel Pay, Stock & Benefits Handbook is the Summary Plan Description (“SPD”) for the Intel Group Health Plan. This PBB should be kept with your Intel Pay, Stock & Benefits Handbook, the Intel Pay, Stock & Benefits Handbook is the prevailing document.*

*Intel reserves the right to modify, change, or discontinue benefits plans at anytime, and at its sole discretion.*