Benefit Booklet

State of New Mexico PPO Plan

A Guide to Your Preferred Provider Option Plan

Administered by:

Blue Cross and Blue Shield of New Mexico

A001- Eff. 7/08

Dedicated Service Unit Information

The address for the BCBSNM State of New Mexico (SONM) Dedicated Service Unit (DSU) is:

Street Address (do NOT mail claims to this address)**:**
Blue Cross and Blue Shield of New Mexico
4373 Alexander Blvd. NE

Mailing Address: Mail correspondence and medical/surgical claims for services received in New Mexico to:
Blue Cross and Blue Shield of New Mexico
Attn: SONM DSU
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Customer Service Phone Numbers/Hours:
Monday through Friday from 6 A.M.– 8 P.M. and 8 A.M.– 5 P.M. on Saturdays and most holidays.*

1-877-994-2583

*NOTE: If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service representative will return your call by 5 P.M. the next business day.

Web Site: For provider network information, claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM Web site:

www.bcbsnm.com

Health Services: When you or your provider need to obtain admission review or other prior approval for a medical or surgical admission or service, call BCBSNM's Health Services Department:

Monday–Friday: 8 A.M. to 5 P.M., Mountain Time
1-800-325-8334 or (505) 291-3585

Note: Prior approvals and preadmission review approvals are not processed after 5 P.M.

Mental Health and Substance Abuse: When you or your provider need to obtain prior approval or pre-admission review for mental health services or substance abuse treatments, call Mesa Mental Health:

24 hours/day, 7 days/week **1-800-583-6372 or (505) 816-6792;** www.mesamentalhealth.com

Mailing Address (submit claims* to):
Mesa Mental Health
P.O. Box 92165
Albuquerque, New Mexico 87199-2165

Mailing Address (for written inquiries):
Mesa Mental Health
P.O. Box 90607
Albuquerque, New Mexico 87199-0607

Prescription Drugs: Prescription drugs are administered by Express Scripts. For customer service, call the Express Scripts Customer Service Center:

1-877-849-5530

Services Outside New Mexico: Claims for medical/surgical and behavioral health services received from providers that do not contract directly with BCBSNM (or Mesa Mental Health), should be sent to the Blue Cross Blue Shield Plan in the state where services were received. See *Section 7* for details on submitting claims.

Welcome

This booklet describes your group medical benefits. The State of New Mexico strongly believes in providing for employees' protection and welfare and is pleased to offer this Plan.

This booklet is intended to provide you with easy-to-understand general explanations of the more significant provisions of your Plan, effective July 1, 2008. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this booklet and the claims administrative procedures of our Third Party Claim Administrator, Blue Cross and Blue Shield of New Mexico (BCBSNM), or if any provision is not covered or only partially covered, the terms of this benefit booklet will govern in all cases.

This booklet does not imply a contract of employment. The State of New Mexico reserves the right to terminate, discontinue, alter, modify, or change this Plan or any provision of this Plan at any time.

It is your responsibility to read and understand the terms and conditions in this booklet. You are urged to read this booklet carefully and use it to make well-informed benefits decisions for you and your family.

Very truly yours,

General Services Department, Risk Management Division (GSD/RMD)

Table of Contents

Summary of Benefits: July 1, 2008

The following are the highlights of the State of New Mexico PPO Plan administered by Blue Cross and Blue Shield of New Mexico. Any services received must be medically necessary to be covered. The specific terms of coverage, limitations, and exclusions are detailed in a separate document.

Benefit Highlights		Preferred Provider[1,2]	Nonpreferred Provider[1,2]
Highlights of Cost-Sharing Features	Annual Plan Year Deductible[1] (Family deductible is an aggregate amount that may be met by three or more family members combined.) **NOTE**: All services are subject to deductible except preventive care, certain diagnostic tests, and PPP office services.	$100 Individual $200 Two-Person $300 Family	$500 Individual $1,000 Two-Person $1,500 Family
	Annual Plan Year Out-of-Pocket Limit[2] (Includes medical plan deductible, coinsurance, and copayments only; NOT drug plan payments, penalty amounts, or noncovered charges.)	$2,000 Individual $5,000 Family	$4,000 Individual $10,000 Family
	Lifetime Maximum	Unlimited (Certain services are subject to Plan year and/or lifetime maximums or are limited per condition.)	
Type of Service	**Description of Service and Limitations**	**Your Share After Plan Year Deductible [1,2]**	
		Preferred Provider	**Nonpreferred Provider**
Physician Services, Office	PPO Primary Provider (PPP) Office Visit/Exam Copayment (nonpreventive) - Office Surgery (including casts, splints, etc.) - Lab Tests, X-Rays, EKGs, Other Diagnostics	$15 per visit (deductible waived) $15 per visit (deductible waived)[4] No copay (deductible waived)	Not Applicable
	Other Non-Routine Office Services: Includes services of non-PPP preferred providers (PPO Specialists) and nonpreferred providers. - Office Surgery - Therapeutic Injections, Allergy Injections, Tests, Serum	$25 per visit[4]	30%[4]
	Preventive Adult Services, including immunizations, lab, x-ray, colonoscopies, Pap tests, mammograms, immunizations, and other wellness services	No copay (deductible waived)	30% (deductible waived)
	Preventive Well-Child Care (through age 17), including lab, x-ray, immunizations, routine vision screening, etc. Hearing screenings (up to age 25)	No copay (deductible waived)	30% (deductible waived)
Diagnostic Testing	- PET scans[4], CT scans[4], MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.) - Other lab, x-ray, home sleep studies[4], genetic testing & counseling[4]; EKGs	10%[4] (up to a max. member share of $200 per test) No copay (deductible waived)	30%[4]
Inpatient Hospital Services, Acute Care	Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist)	$300 per admission[5] No copay for related physician	30%[3,5]
Outpatient Hospital Services	Surgery – operating and recovery room; Observation (nonemergency)	10%[4] $150 per visit	30%[4]
	Other treatment room services (e.g., radiation therapy)	$150 per visit[4]	30%[4]
	Related physician services	No copay for surgery-related, 20% all other	30%
Emergency Services and Urgent Care	Emergency room visit (deductible applies)	$150 per visit	$150 per visit[3]
	Urgent care center	$35 per visit	$35 per visit
	Ambulance (nonemergency air transfer)	20%[4]	30%[3,4]
	Ambulance (ground and emergency air transport)	20%	20%[3]

Type of Service	Description of Service and Limitations	Your Share After Plan Year Deductible [1,2]	
		Preferred Provider	Nonpreferred Provider
Transplants	Bone marrow, heart, heart-lung, liver, lung, pancreas-kidney, and other medically necessary transplants (Case management required. Maximums apply to covered travel, food, & lodging.)	Applicable copays based on place and type of service [4,5,6]	Not Covered
Maternity Services	Initial visit to confirm pregnancy	$15 for initial visit if to a PPP (deductible waived)	30%
	Physician/midwife services (delivery, prenatal/postnatal care)	Applicable copays based on place and type of service [4,5,6]	30%
	Hospital admission	$300 per admission [5]	30% [5]
	Routine nursery care for covered newborn (Child covered from birth, but must apply for coverage within 31 days.)	No copay [5]	30% [5]
Mental Health Services	- Outpatient/office services - Inpatient services - Partial hospitalization - Intensive outpatient program - Residential treatment center (max. **60 days**/Plan year in combination with substance abuse services)	$25 per visit [4] $300 per admission [5] $150 per admission [5,7] $75 per visit [4,7] $300 per admission [5] Related inpatient, RTC, and partial hospital physician charges = 20%	30% [4,5]
Substance Abuse (Alcoholism and Drug Abuse) Rehabilitation*	- Outpatient/office services (max **30 visits/**Plan year) - Intensive outpatient program (applied to outpatient benefit maximum of **30 visits/**Plan year) - Inpatient services; Partial hospitalization (max. **30 days/**Plan year for both combined) - Residential treatment center (max. **60 days**/Plan year in combination with nonsubstance abuse) Note: Substance abuse limited to services received within a maximum of **two 12-month** benefit periods.	$25 per visit [4] $75 per visit [4,7] $300 per inpatient admission [5] $150 per partial admission [5,7] $300 per admission [5] Related inpatient, RTC, and partial hospital physician charges = 20%	30% [4,5]

** To obtain mental health or substance abuse services, you must call Mesa Mental Health at 1-800-583-6372.*

Other Office and Home Services	Acupuncture, rolfing, massage therapy, chiropractic treatment (max. benefit of **$1,500/**Plan year)	$25 per visit[8]	30%[8]
	Biofeedback (for specified conditions only)	$25 per visit	30%
	Cardiac or pulmonary rehabilitation	$25 per visit[4]	30%[4]
	Chemotherapy; radiation therapy; dialysis	$25 per visit[4]	30%[4]
	Chronic pain treatment	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment [4]	
	TMJ/CMJ, oral surgery, & dental accident services	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment [4,5]	
	Durable medical equipment, diabetic equipment and supplies; orthopedic appliances, prosthetics and orthotics (Rental benefits not to exceed the purchase price of a new unit. Supplies limited to a **30-day supply** during a 30-day period.)	20% [4] (unlimited benefit)	30% [4] (Max. benefit of **$1,000/**Plan year)
	Hearing exam/test Hearing aids	$25 per visit[4] 15%[4]	30%[4] 15%[4]
	Home health care and home I.V. services (up to **100 visits**/Plan year)	$25 per visit [4]	30% [4]
	Hospice (lifetime max. benefit of **$7,500)**	No copay [4]	30% [4]
	Insulin supply purchased at a physician's office	20% [4]	30% [4]
	Naprapathy treatment (max. benefit of **$1,500/**Plan year)	$25 per visit[8]	30%[8]
	Smoking/tobacco use cessation	50%	50%
	Short-term rehabilitation: inpatient and outpatient physical, occupational, and speech therapies, rehabilitation facility, skilled nursing facility	$25 per office/outpatient [4,8] $300 per admission [5] (related professional charges = no copay)	30% [4,5]

Footnotes:

1 All benefits are based on the covered charge as determined by BCBSNM. The deductible must be met before benefit payments are made for most covered services in a Plan year (excluding PPP office visits, preventive services, and most diagnostic lab and x-ray services). Preferred provider amounts cross-apply to the nonpreferred provider deductible and vice versa. A Plan year begins July 1 each year and ends on June 30 of the following year. Any amounts applied to the Plan year deductible during the last quarter of the Plan year (i.e., April 1 through June 30) will be used to help satisfy the next Plan year deductible. Note: A "PPP" is any preferred provider with a specialty of Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or Obstetrics/Gynecology.

2 After you reach the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of your covered preferred or nonpreferred provider charges, whichever is applicable, for the rest of the Plan year. Preferred provider amounts cross-apply to the nonpreferred provider limit and vice versa. Amounts in excess of covered charges do not count toward the out-of-pocket limit or deductible.

3 Initial treatment of a medical emergency at a preferred or nonpreferred emergency room or trauma center is paid at the Preferred Provider benefit level. If you must be admitted as an inpatient as a result of an emergency, the entire, related hospitalization is paid at the Preferred Provider benefit level. Follow-up treatment and treatment that is not for an emergency are paid at the Nonpreferred Provider level. The emergency room or observation room copayment is waived if an inpatient admission results; then inpatient hospital benefits apply.

4 Certain services are not covered if prior approval is not obtained from BCBSNM. Nonemergency air ambulance transfer services are covered only when it is medically necessary to transfer the patient from one facility to another. A list of services requiring prior approval is in *Section 2*.

5 Admission review approval is required for inpatient admissions. You pay a $300 penalty for covered nonemergency medical/surgical facility services if admission review approval is not obtained before being admitted to a nonpreferred facility. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related admissions will be denied. The $300 penalty will not apply in such cases. See *Section 2* for details.

6 Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.

7 The partial hospitalization and facility-based intensive outpatient program (IOP) copayments are waived if the patient is directly admitted into either program from an inpatient facility, or if the patient is admitted into a partial hospitalization program directly from an inpatient facility.

8 Covered massage therapy received as part of a chiropractic or physical therapy session are covered under either the chiropractic service benefit (when rendered by a chiropractor), or as part of the short-term rehabilitation benefit (when rendered by a licensed medical doctor, doctor of osteopathy, registered physical therapist, licensed physical therapist, or doctor of oriental medicine). Massage therapy under the "Alternative Therapy" benefit must be provided by a licensed massage therapist. Rolfing must be provided by a licensed rolfer.

Administered by:

Blue Cross and Blue Shield of New Mexico

BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Professional Services Agreement.

1 How to Use This Benefit Booklet

This benefit booklet describes the coverage available to members of this health care Plan and benefit limitations and exclusions.

Summary of Benefits

Starting on page iv of this benefit booklet, there is a *Summary of Benefits* that shows specific member cost-sharing amounts of this Plan. Throughout this booklet, you are asked to refer to the *Summary of Benefits f*or specific benefit and cost-sharing information. You will receive a new *Summary of Benefits* if changes are made to your health care Plan.

Other Benefit-Related Materials

In addition to this booklet you should have the following benefit-related documents:

ID Card — Your BCBSNM identification (ID) card shows that you are a member of a plan administered by BCBSNM. It shows the PPO Primary Provider (PPP) office visit copayment and the individual Preferred Provider deductible. The ID card provides the information needed when you require health care services or mental health/substance abuse services, or when you are contacting a Customer Service representative. Carry it with you. Have your ID card handy when you call for an appointment and show it to the receptionist when you sign in for an appointment. (You should have a separate ID card for prescription drugs.)

This card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact a Customer Service representative.

Drug Plan Booklet and Brochure — In addition to this benefit booklet, you should have received a drug plan booklet from the drug plan administrator. It provides important information about your drug plan benefits. (The State of New Mexico has contracted with a separate program for administration of outpatient prescription drug benefits, which includes coverage for other items, such as diabetic supplies. This program is not an affiliate of BCBSNM.)

Provider Network Directory — The provider network directory is available through the BCBSNM Web site at www.bcbsnm.com. It lists all providers in the BCBSNM preferred provider network, including mental health/substance abuse providers. It also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service and it will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider's status or if you have any questions about how to use the directory, contact a Customer Service representative or visit the BCBSNM Web site.

BlueCard Brochure — As a member of a PPO health plan administered by BCBSNM, you take your health care plan benefits with you – across the country and, for emergency services, around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross Blue Shield Plans, so you and your dependents can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM Web site at www.bcbsnm.com.

Using the Informational Graphics

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements. Some commonly used symbols are:

Definitions

This symbol calls attention to definitions of important terms throughout this booklet. More definitions are in the *Glossary*. If you are unsure of the meaning of a term, please check the *Glossary* to see if the definition has been included.

Limitations and Exclusions

Each subsection in *Section 4* not only describes what is covered, but may list limitations and exclusions that specifically relate to a particular service. *Section 5: General Limitations and Exclusions* lists limitations and exclusions that apply to *all* services. This graphic symbol will be next to limitations or exclusions listed in *Section 4*.

Cross-References

Throughout this benefit booklet, cross-references direct you to read other sections of the booklet. You will see this symbol next to such references in *Section 4*.

Call Mesa Mental Health for Prior Approval

For all mental health and substance abuse services (which includes alcoholism and drug abuse rehabilitation services), you or your provider must call Mesa Mental Health before you schedule treatment. Mesa Mental Health will coordinate your covered services. Benefits for services that are not approved in advance by Mesa Mental Health may be reduced or denied. Call toll-free at 1-800-583-6372, or (505) 816-6792 in Albuquerque, 7 days a week, 24 hours a day.

Admission Review or Other Prior Approval Required

To receive full benefits for some medical/surgical services, you or your provider must call the BCBSNM Health Services department **before** you receive treatment. Also, if you have a routine maternity delivery of a newborn child and stay in the hospital more than 48 hours, or if you have a C-section delivery and stay in the hospital more than 96 hours, you must call BCBSNM for admission approval before you are discharged. This symbol is a reminder to do so. Call Monday – Friday, 8 A.M. to 5 P.M., Mountain Time. (If you need assistance with an approval

after 5 P.M. or on weekends, please call Customer Service.) See *Section 2* for details.

Call Within 48 Hours
(505) 291-3585
(800) 325-8334

Emergency Admission Notification — To ensure that benefits are correctly paid and to find out if an admission you believe is emergency-related will be covered, you or your physician or hospital should notify BCBSNM within 48 hours or as soon as reasonably possible following admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Time.

Written Request Required — If a written request for prior approval is required in order for a service to be covered, the provider should send the request, along with appropriate documentation, to:

Blue Cross and Blue Shield of New Mexico
Attn: Health Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

Written requests may also be submitted over the BCBSNM Web site at www.bcbsnm.com. Please ask your health care provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.

Dedicated Customer Service

If you have any questions about your coverage, call or e-mail BCBSNM's Customer Service department. Representatives are available Monday through Friday from 6 A.M.– 8 P.M. and 8 A.M.– 5 P.M. on Saturdays and most holidays. For your convenience, the toll-free customer service number is printed at the bottom of every page in this booklet. A complete list of Customer Service and prior approval phone numbers and addresses is also printed on the inside front cover of this booklet. (Questions about mental health and substance abuse services should be directed to Mesa Mental Health. Questions about prescription drug benefits should be directed to the prescription drug plan administrator, Express Scripts.)

2 How Your Plan Works

The State of New Mexico (SONM) PPO Plan is a Preferred Provider Option (PPO) health care plan that gives you the opportunity to save money, while providing you choice and flexibility when you need medical/surgical care and preventive services. When you need health care, you have two choices: Preferred Provider (including a PPP office visit option) or Nonpreferred Provider Services:

Your Choice

PPO Plan Feature	Preferred Provider Services	Nonpreferred Provider Services
Covered Charges and the Member's Share	If the covered charge is less than the billed amount, the provider will write off the difference. You pay only deductible, copayments, coinsurance, noncovered expenses, and penalty amounts, if any.	You may have to pay amounts above the covered charge.* (Note: These amounts can be significant, so you are encouraged to obtain an estimate from nonpreferred providers regarding how much you will owe.)
Member Cost-Sharing	For most covered services from a Preferred Provider, you pay an annual deductible and a percentage of covered charges (coinsurance) or a fixed-dollar copayment after the deductible, if applicable, is met. You do not need to meet the deductible for PPP office visits and office surgery, or emergency room services. Preventive services and most diagnostic tests are paid at 100 percent, no deductible.	For services covered at the Nonpreferred Provider level, you pay a higher annual deductible and a higher coinsurance percentage. You do not have to meet a deductible for preventive services (but must still pay a percentage of the covered charge) or emergency room services.
Out-of-Pocket Limits	You have an annual out-of-pocket limit (includes both Preferred and Nonpreferred Provider benefit level copayments, deductible, and coinsurance).	You have a higher annual out-of-pocket limit to meet for Nonpreferred Provider services.
PPP Office Visit Copayment	Nonpreventive PPO Primary Provider (PPP) office visit charges are subject to a fixed-dollar copayment with no deductible to meet (see "Cost-Sharing Features" for details). Most other services of a PPP and nonpreventive office services of PPO Specialists are subject to deductible and coinsurance.	Nonpreferred provider services are not eligible for the PPP office visit copayment — even if required due to an emergency.
Filing Claims	The provider files claims for you.	You may have to pay the provider in full and submit your own claims; the decision is up to the provider.
Requesting Prior Approvals	Preferred providers that contract directly with BCBSNM will obtain necessary prior approvals and admission review for you.	Nonpreferred providers may call for prior approvals on your behalf, but you are responsible for making sure that all approvals are obtained when required.
Covered Services	All services covered under this Plan are eligible for coverage at the Preferred Provider benefit level.	Some transplants are not available unless services are received from a preferred provider.

*** Note:** The "covered charge" is the amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., deductible, copayment, coinsurance, penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. **The covered charge may be less than the billed charge.** Your choice of provider will determine if you will also have to pay the difference between the covered charge and the billed charge.

The State of New Mexico PPO health care plan includes these special features:

- You can choose at the time that care is needed whether to see a preferred provider or another provider.
- If you choose to visit a preferred provider from an extensive network of preferred providers that contract with BCBSNM and other Blue Cross Blue Shield (BCBS) Plans throughout the United States, you will receive the higher, Preferred Provider (PPO) benefit level for covered services.
- If you receive covered services from providers outside the preferred provider network, benefits will be paid at the Nonpreferred Provider benefit level. You may also be responsible for any amount above covered charges. (Some services are **not covered** unless received from a preferred provider.)

Preferred vs. Nonpreferred Providers

Preferred providers — Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as "preferred" or "PPO" providers. These providers have agreed to provide health care for PPO Plan members and accept the Plan's payment for a covered service plus the member's share of the covered charge (i.e., deductible, coinsurance, penalty amount, if any) as payment in full.

Nonpreferred providers — Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "preferred" or "PPO" provider network. (These providers may have "participating" provider agreements, but are **not** considered preferred. See "Filing Claims" in *Section 7* for more information.)

See "Cost-Sharing Features," on the next page, for information about special "PPP" benefits and the office visit copayment.

When you receive most medical care, you have the choice of selecting a preferred provider or a nonpreferred provider. It's important to understand the differences between them. Your choice can make a difference in the amount you pay and the benefits available to you. The advantages of choosing a **preferred provider** when you need medical care are listed on the table at the beginning of this section.

When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a preferred provider. (A physician's or other provider's contract may be separate from the facility's contract.)

Selecting a PPP or Other Preferred Provider — When you need medical care in New Mexico (or along the border of neighboring states), use the *BCBSNM Preferred Provider Network Directory* to choose a PPP or other preferred provider. All providers listed in the *BCBSNM Preferred Provider Network Directory* are preferred providers. The "Introduction" will tell you how to use the directory. The directory also lists mental health providers (including those specializing in substance abuse), and is available through the BCBSNM Web site at www.bcbsnm.com. The Web site directory also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service and it will be mailed to you free of charge.)

Note: Only those providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology, and Pediatrics are considered PPO Primary Providers (PPPs). See "Cost-Sharing Features," on the next page, for details.

To verify a provider's current status or if you have any questions about how to use the directory, contact a BCBSNM Customer Service representative or visit the BCBSNM Web site at www.bcbsnm.com.

Note: Although provider directories are current as of the dates shown at the bottom of each page, they can change without notice. If you do not have a current directory, ask a BCBSNM Customer Service representative to send you one or visit the BCBSNM Web site at www.bcbsnm.com.

Outside New Mexico — For a list of contracting providers outside New Mexico,, or when you are traveling and need services, call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583) or visit the BCBSNM Web site at www.bcbsnm.com. (If you are in an emergency situation, call 911 if necessary or go directly to the nearest emergency room.)

When you call, a BlueCard representative will give you the name and telephone number of a local provider who will be able to call Customer Service for eligibility information and will submit a claim for the services provided to the local BCBS Plan. Preferred providers in other states are also eligible for the Preferred Provider level of benefits, including the PPP office visit copayment (if they are considered "PPO Primary Providers" as defined under "Cost-Sharing Features: Fixed-Dollar Copayments," later in this section).

If you have an Internet connection, you may also check the BCBSNM Web site at bcbsnm.com and be linked to the national provider location system: After reaching the BCBSNM Web site, click on "Provider Finder®" and then link to the line item entitled "Providers located outside New Mexico." You will then be linked to the Blue Cross Blue Shield Association's BlueCard Doctor and Hospital Finder. You can also connect to the national provider location system at www.bcbs.com.

Out-of-state providers that contract with their local Blue Cross and/or Blue Shield Plan also accept covered charges as payment in full. Please call a BCBSNM Customer Service representative for a list of preferred providers with the Plan in your state (you will be asked for your zip code), or use the Internet to find a provider near you by following the instructions above. **Note:** Providers who have a "participating-only" contract are **not** "preferred" providers and you will not receive the Preferred Provider benefit level when receiving services from participating-only providers. You must use **preferred** providers in order to obtain the higher benefit.

Cost-Sharing Features

Plan year — July 1 through June 30 of the next year. The initial Plan year benefit period is from a member's effective date of coverage through the next following June 30, which may be less than 12 months. For example, deductible amounts and acupuncture maximums start accruing for a Plan year on July 1.

Most covered services are subject to an annual Plan year deductible plus a percentage of covered charges or a fixed-dollar copayment. This section describes each of those cost-sharing features.

Note: Any amounts applied to the Plan year deductible during the last quarter of the Plan year (i.e., April 1 through June 30) will be used to help satisfy the next Plan year deductible.

Annual Plan Year Deductibles

Deductible — The amount of covered charges that you must pay in a Plan year before this Plan begins to pay its share of the applicable (preferred or nonpreferred) covered charges you incur during the rest of the same Plan year. If the deductible amount remains the same during the Plan year, you pay it only once each Plan year, and it applies to all preferred provider or nonpreferred provider covered services you receive during that Plan year.

See your Summary of Benefits for your deductible amounts, copayments, coinsurance percentages, and out-of-pocket limit amounts.

Individual Deductibles — There are two individual deductible amounts indicated on your *Summary of Benefits.* Once a member's deductible payments for preferred provider services reach the individual Preferred Provider deductible amount during a Plan year, this Plan will begin paying its share of that member's covered preferred provider charges for the remainder of the Plan year.

The deductible amounts for Preferred Provider services are also applied to the member's Nonpreferred Provider deductible, and vice versa. However, once the Preferred Provider deductible is met, no more charges for the services of a preferred provider (such as copayments and coinsurance) may be used to help satisfy the remainder of the higher Nonpreferred Provider deductible. The member must meet the higher Nonpreferred Provider deductible before this Plan begins to pay its share of his/her covered charges from nonpreferred providers.

Two-Person Deductibles — If you have a Two-Person contract, each member must meet his/her own individual Plan year deductibles, as explained above.

Family Deductibles — If you have a Family contract, an entire family meets an applicable deductible for a Plan year when the total deductible amount for all family members reaches three times the individual deductible amount (the deductible amounts for three or more family members are combined to satisfy the family deductible). However, once a member meets an individual deductible, that member's applicable deductible is satisfied for the Plan year, and no more charges incurred by that member under that benefit level can be used to satisfy the family deductible.

What is Not Subject to Deductible — PPO Primary Provider (PPP) office services, including office visits and office surgery, most diagnostic services received from a preferred provider, mental health and substance abuse services, routine and preventive services of any covered provider, and emergency room visits are not subject to the annual deductible.

Admissions Spanning Two Benefit Periods — If a deductible has been met while you are an inpatient and the admission continues into a new Plan year, no additional deductible is applied to that admission's covered services. However, all other services received during the new Plan year are subject to the deductibles for the new Plan year.

Timely Filing Reminder — Most benefits are payable only after BCBSNM's records show that an applicable deductible has been met. Preferred providers and providers that have "participating" provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time. If you file your own claims for services from nonparticipating providers, you must file them within **12 months** of the date of service. If a claim is returned for further information, resubmit it **within 45 days.** See "Filing Claims" in *Section 7.*

Fixed-Dollar Copayments

PPP (PPO Primary Provider) — A preferred provider in one of the following medical specialties **only:** Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery, or Pediatric Allergy.

PPP Copayment — When you receive **office services** from a **PPP,** you pay only a fixed-dollar amount, or copayment, for his/her covered office visit or routine physical exam (the annual deductible is waived). All other PPP services received during the office visit, including office surgery and diagnostic tests are also covered by the copayment, which is listed on your *Summary of Benefits.*

Other Copayments — For some other services list on the *Summary of Benefits,* (e.g., emergency room visits), you pay a fixed-dollar copayment for covered services; for inpatient admissions, nonemergency observation, hospital treatment room charges, home health care, and urgent care facility visits, you pay the fixed-dollar copayment *after* meeting the annual Plan year deductible.

Outpatient services copayments usually include all services received during the visit, such as emergency room physician charges, or lab tests.

The inpatient facility copayments cover only the facility's fee. Related inpatient and partial hospitalization professional provider services (such as admitting physician, psychiatrist, surgeon, anesthesiologist, and consultants) are subject to deductible and coinsurance provisions. If you are directly admitted as an inpatient from an emergency room or other outpatient department of a hospital, the outpatient copayment is waived for facility services, and hospital inpatient benefits apply to covered facility services.

Coinsurance

Coinsurance — The **percentage** of covered charges that you must pay for some covered services after the applicable deductible has been met.

For most covered services, you must pay a percentage of **covered charge**s as "coinsurance." After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any. You pay a lower percentage of covered charges when you visit a preferred provider. **Note:** Covered routine and preventive services, lab, x-ray, and most other diagnostic tests are paid at 100 percent of the covered charge when received from a **preferred provider.** If you must go to an independent lab or x-ray facility to receive preventive services or other diagnostic tests, please make sure that the facility you visit is a preferred provider. **Preventive services and diagnostic tests received from a nonpreferred provider** are subject to **nonpreferred provider benefit provisions.**

Remember: The covered charge may be less than the billed charge for a covered service. **Preferred providers may not bill you more than the covered charge; nonpreferred providers may.**

Out-of-Pocket Limits

Out-of-pocket limits — The maximum amount of deductible, copayment amounts, and coinsurance that you pay for covered services in a Plan year. After an out-of-pocket limit is reached, this Plan pays 100 percent of most of your preferred or nonpreferred provider covered charges for the rest of that Plan year, not to exceed any benefit limits.

Individual Out-of-Pocket Limits — Once a member's deductible, copayment, and coinsurance amounts for preferred provider services reach the individual Preferred Provider amount indicated on the *Summary of Benefits* during a Plan year, this Plan pays 100 percent of that member's covered preferred provider charges for the rest of the Plan year.

The amounts applied to the out-of-pocket limit for Preferred Provider services are also applied to the member's Nonpreferred Provider limit, and vice versa. The higher Nonpreferred Provider limit must be met using amounts paid for covered nonpreferred provider services before this Plan pays 100 percent of the member's covered charges for nonpreferred provider services.

Two-Person Limits — If you have a Two-Person contract, each member must meet his/her own individual out-of-pocket limit before that member's covered charges – preferred or nonpreferred – are paid at 100 percent for the Plan year, as explained above.

Family Limits — An entire family meets an annual out-of-pocket limit when the total deductible, copayments, and coinsurance for all family members reaches the amount specified on the *Summary of Benefits* during a Plan year (the amounts for three or more family members are combined to satisfy the family limit). When a member meets an out-of-pocket limit, no more charges incurred by that member may be used to satisfy an applicable family out-of-pocket limit.

What is Not Included in the Limits — The following amounts are **not** applied to the out-of-pocket limits and are not eligible for 100 percent payment under this provision:

- penalty amounts; amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits); noncovered expenses (including services in excess of annual or lifetime day/visit limitations)
- prescription drug plan payments
- most mental health and chemical dependency services (Certain services received outside New Mexico or coordinated with Medicare as the primary coverage *are* applied to the limit.)

Exceptions to Cost-Sharing Provisions

Services of nonpreferred providers will be paid at the Preferred Provider benefit level in the following instances only.

Except as described on the next page, the Preferred Provider benefit level is not available for nonemergency services when received from a nonpreferred provider — even if a preferred provider is not available in your area to perform the services.

Emergency Care Exception — If you visit a nonpreferred provider for emergency room services, the Preferred Provider benefit level is applied only to the initial treatment in the emergency room and (and, if you are hospitalized as an inpatient from the emergency room, the related inpatient hospitalization). Office/urgent care facility services are not considered "emergencies" for purposes of this provision. Follow-up care (which is no longer considered an emergency) and all other covered nonemergency services of a nonpreferred provider, will be covered only at the Nonpreferred Provider benefit level, even if a preferred provider is not available to perform the service. See "Emergency and Urgent Care" in *Section 4* for more information.

Unsolicited Providers — In some states, the local BCBS Plan does not offer preferred provider contracts to certain types of providers (e.g., home health care agencies, chiropractors, ambulance providers). These provider types are referred to as "unsolicited providers." The types of providers that are unsolicited varies from state to state. If you receive covered services from an "unsolicited provider" outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, the unsolicited provider may still bill you for amounts that are in excess of covered charges. You will be responsible for these amounts, in addition to your deductible and coinsurance. **Exception:** Preferred Provider benefits are **not** available for rolfing or for the services of a licensed massage therapist (L.M.T.) unless you visit a **contracted** rolfer or L.M.T. (Most BCBS Plans, including BCBSNM, do not contract with rolfers or massage therapists and this "Unsolicited Providers" provision does not apply to their services.)

Ancillary Provider Exception — Once you have obtained prior approval for an inpatient admission to a preferred hospital or treatment facility, your preferred physician or hospital will make every effort to ensure that you receive ancillary services from other preferred providers. If you receive covered services from a **preferred** physician for outpatient surgery or inpatient medical/surgical care in a preferred hospital or treatment facility, services of a nonpreferred radiologist, anesthesiologist, or pathologist will be paid at the Preferred Provider level and you will not be responsible for any amounts over the covered charge (these are the only three specialties covered under this provision). If a **nonpreferred** surgeon provides your care or you are admitted to a nonpreferred hospital or other treatment facility, you **will** be responsible for amounts over the covered charge for any services received from nonpreferred providers during the admission or procedure.

Transition of Care — If your health care provider leaves the BCBSNM PPO provider network (for reasons other than medical competence or professional behavior) or if you are a new member and your provider is not in the PPO provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional care from other non-PPO providers.) The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery. Call the BCBSNM Customer Service department for details.

The above situations are the only instances in which a member may receive Preferred Provider benefits for the covered services of a nonpreferred provider.

Changes to the Cost-Sharing Amounts

Coinsurance percentage amounts, deductibles, and out-of-pocket limits may change during a Plan year. If changes are made, the change applies only to services received after the change goes into effect. You will receive a revised *Summary of Benefits* and/or a new ID card if changes are made to this Plan.

If the State increases the deductible or out-of-pocket amounts during a Plan year, the new amounts must be met during the same Plan year. For example, if you have met your deductible and the State changes to a higher deductible, you will not receive benefit payments for services received after the change went into effect until the increased deductible is met. If the State decreases the deductible or out-of-pocket amounts, you will not receive a refund for amounts applied to the higher deductible or out-of-pocket limit.

Benefit Limits

Plan year — July 1 through June 30 of the next year. The initial Plan year benefit period is from a member's effective date of coverage through the next following June 30, which may be less than 12 months.

There is no general lifetime maximum benefit. However, certain services have separate benefit limits per admission, per contract year, per lifetime, etc. **See the *Summary of Benefits*.**

Note: Any benefits that are limited on a Plan-year basis (e.g., acupuncture, chiropractic, and home health care), will start accruing on July 1 each year. Any benefits you received during the first half of a calendar year (i.e., January 1 through June 30) will **not** be applied to benefit limitations for the July 1 Plan year that ends on June 30.

Generally, benefits are determined based upon the coverage in effect on the day a service is received, an item is purchased, or a health care expense is incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date. Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Plan.

Admission Review and Other Prior Approvals

Prior approval — A requirement that you or your provider must obtain authorization from BCBSNM before you are admitted as an inpatient (admission review approval) or receive certain types of services (other prior approvals).

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care. (Admissions and other services related to mental illness, alcoholism, or drug abuse require prior approval from Mesa Mental Health.) Please note:

Prior Approval Does Not Guarantee Payment or Validate Eligibility

Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee your eligibility for coverage. Eligibility and benefits will be determined based on the date you receive a service, purchase an item, or incur a health care expense.

An approval (for example, to receive a nonspecified service from a particular provider) does not guarantee payment or that you will receive the highest level of benefits. Services not listed as covered, services received after your termination date under this Plan, and services that are not medically necessary will be denied.

When You Have Other Coverage

Even when this Plan is not your primary coverage, these approval procedures must be followed. **Failure to do so may result in a reduction or a denial of benefits.**

Retroactive Approvals Not Given

Retroactive approvals will not be given and you may be responsible for the charges if approval is not obtained **before** the service is received.

BCBSNM Preferred Providers — If the attending physician is a preferred provider that contracts **directly** with BCBSNM, obtaining prior approval is not your responsibility — it is the provider's. Preferred providers contracting with BCBSNM must obtain **prior approval** from BCBSNM (or from Mesa Mental Health, when applicable) in the following circumstances:

- when recommending any nonemergency admission, readmission, or transfer
- when a covered newborn stays in the hospital longer than the mother
- before providing or recommending a service listed under "Other Prior Approvals," later in this section.

Remember: Providers that contract with other Blue Cross Blue Shield Plans are not familiar with the prior approval requirements of BCBSNM. Unless a provider contracts directly with BCBSNM as a preferred provider, the provider is not responsible for being aware of this Plan's admission review and other prior approval requirements.

Nonpreferred Providers or Providers Outside New Mexico — If any provider outside New Mexico or any nonpreferred provider recommends an admission or a service that requires prior approval, the provider is **not** obligated to obtain the prior approval for you. In such cases, it is **your** responsibility to ensure that approval is obtained. If approval is not obtained **before** services are received, **you will incur a penalty for a covered admission or, for some services, be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM (or Mesa Mental Health, when applicable) is called:

BCBSNM: Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time
(505) 291-3585 or toll-free, at (800) 325-8334

Mesa Mental Health (for mental health and chemical dependency):
(505) 816-6792 or toll-free, at (800) 583-6372

Admission Review Approval

Admission review is required for most admissions **before** you are admitted to the hospital or skilled nursing, physical rehabilitation, or other treatment facility. If you do not obtain admission review approval within the time limits indicated in the table below, benefits will be **reduced or denied** as explained on the next page:

Type of inpatient admission, readmission, or transfer	When to obtain admission review approval:
Nonemergency	**Before the patient is admitted.**
Emergency, nonmaternity	**Within 48 hours of the admission.** If the patient's condition makes it impossible to call within 48 hours, call as soon as possible.
Maternity-related (including eligible newborns when the mother will not be covered under the Plan)	**Before the mother's maternity due date,** soon after pregnancy is confirmed. However, you should always call within 48 hours of the admission for routine deliveries and 96 hours for C-sections. If the mother's condition makes it impossible to call within 48 (or 96) hours, call as soon as possible.
Extended stay, newborn (when an eligible newborn stays in the hospital longer than the mother)	**Before the newborn's mother is discharged.**

How the Approval Procedure Works — When you or your provider call, BCBSNM's Health Services staff will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services staff will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization are approved. If the admission is not approved, you may appeal the decision as explained in *Section 7*.

Penalty for Not Obtaining Approval — If you or your provider does not call, or if you call and do not receive approval for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid or partial payment may be made, as indicated in the table below:

If, based on a review of the claim:	Then:
The admission was **not for a covered service.**	Benefits for the facility and all related services are **denied.***
The admission was for an item listed under **"Other Prior Approvals,"** on the next page (e.g., varicose vein surgery).	Benefits for the facility and all related services are **denied.***
The admission was for any other covered service but hospitalization was **not medically necessary.**	Benefits are **denied** for **room, board,** and **other charges** that are not medically necessary.*
The admission was for a **medically necessary covered service** (nonemergency).	Benefits for the facility's covered services are **reduced by $300.***

* Note: The admission review penalty of $300 and charges for noncovered and denied services are **not** applied to any deductible or out-of-pocket limit.

Admission review requirements may affect the amounts that this Plan pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services.

Other Prior Approvals

In addition to admission review for all inpatient services, prior approval is required for certain other services. Most prior approvals may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for prior approval. If prior approval is not obtained for the following services, **benefits will be denied** for all related services:

If prior approval is not obtained for the following services, **benefits will be denied** for all related services:

- inpatient **alcoholism** and **drug abuse services** (Prior approval is obtained from Mesa Mental Health.)
- **durable medical equipment, medical supplies,** and **prosthetic** devices requiring rental or costing $500 or more
- **home health care** and **home I.V. services**
- **home uterine monitoring**
- **hospice care**
- certain **injections** or **self-injectable drugs** received in a physician's office (such as growth hormone or interferon alfa-2)
- **orthopedic appliances**
- **orthotics**
- **PET** (Positron Emission Tomography) scans
- **private room** chargesta

- inpatient **psychotherapy** (Prior approval is obtained from Mesa Mental Health.)
- rehabilitative services, inpatient (including skilled nursing facility), outpatient, office, home-based **(physical, occupational,** and **speech** therapy)
- certain **surgical procedures,** including:
  - mastectomy for gynecomastia (breast reduction)
  - decompression of intervertebral disc (kyphoplasty)
  - meniscal transplants
  - weight loss surgery (e.g., gastric stapling)
  - reconstructive surgical procedures
  - saphenous vein ligation; sclerotherapy (varicose vein surgery)
  - trans-myocardial revascularization (TMR)
  - transplants, including pretransplant evaluations

The services listed above may not be approved for payment (for example, due to being experimental, investigational, or unproven, or not medically necessary). It is strongly recommended that you request prior approval for high-cost services, such as nonemergency air ambulance facility transfers, in order to reduce the likelihood of benefits being denied *after* charges are incurred. See "Grievance Procedures" in *Section 7* for information about appealing denials of claims or prior approval requests. The complete list of services requiring prior approval is subject to review and change by BCBSNM. BCBSNM-contracted providers have a list of all procedures and services, including individual surgical procedures and injectable drugs, that require prior approval. If you need a copy of this list, call a Health Services representative.

If You Are Still Not Satisfied — See "Grievance Procedures" in *Section 7* for information about appealing denials of claims or prior approval requests.

Advance Benefit Information

If you want to know what benefits will be paid before receiving services or filing a claim, BCBSNM may require a written request. BCBSNM may also require a written statement from the provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation of benefits does not guarantee benefits if the actual circumstances of the case differ from those originally described. When submitted, claims are reviewed according to the terms of this benefit booklet or any other coverage that applies on the date of service.

Utilization Review and Quality Management

Medical records, claims, and requests for covered services may be reviewed to establish that the services are/were medically necessary, delivered in the appropriate setting, and consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of BCBSNM's professional consultants. Utilization management decisions are based only on appropriateness of care and service. BCBSNM does not reward providers or other individuals conducting utilization review for denying coverage or services and does not offer incentives to utilization review decision-makers to encourage underutilization.

Health Care Fraud Information

Health care and insurance fraud results in cost increases for health care plans. You can help; always:

- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your providers and the Explanation of Benefits (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call a BCBSNM Customer Service representative.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact a BCBSNM Fraud Hotline at 1-888-841-7998.

3 Enrollment and Termination

Who is Eligible

Eligible employees include:

- Employees hired as classified, unclassified, exempt, probationary, temporary, term, or hourly if the employee is scheduled to work at least 20 hours per week and whose term of employment when hired is six months or more.
- Employees and elected officials of participating Local Public Bodies who are not eligible for other group insurance through any other employer-sponsored plan, whether insured or self-insured.

Each person who becomes an eligible employee or dependent after the initial point of service enrollment can apply for coverage by submitting an application to your agency group representative upon becoming eligible.

When two or more family members, including domestic partners, are employed by the State of New Mexico or participating Local Public Bodies, the employee may be covered as an employee or as a dependent but not both. The Plan does not allow dual coverage nor internal coordination of benefits. Independent contractors are not eligible under this Plan.

Contact your agency group representative for eligibility guidelines that apply to you.

Your coverage is one of the following types:

- Employee only;
- Two-Party, including the employee and his/her spouse or one dependent child;
- Family, including the employee, his/her spouse, and/or one or more dependent children.

Eligible dependents include:

- The employee's spouse through legal marriage and not legally separated from the employee (Common-law marriages are not recognized under New Mexico State law, unless you were in a recognized common-law marriage in another state before you moved to New Mexico.)
- The employee's domestic partner (if applicable*). Domestic partners are defined as couples who are in an exclusive and committed relationship for mutual benefit, similar to a marriage relationship in the State of New Mexico. Domestic partners must share a common, primary residence for 12 or more consecutive months, and must be jointly responsible for each other's common welfare, as well as shared financial obligations. Domestic partners must be at least 18 years of age, and may not be married; nor can they be a member of another domestic partnership. Domestic partners are also forbidden from being blood relations to a degree of closeness that would prevent them from being married in the State of New Mexico. A signed Affidavit of Domestic Partnership must be provided in order for a partner to be added as a dependent.

  *** NOTE: If you are an employee of a Local Public Body, please check with your agency's Human Resources office to find out if domestic partners are eligible for coverage.**
- Unmarried children under age 25. Children include natural children, children placed for the purpose of adoption, legally adopted children, stepchildren or children for whom you have court approved legal guardianship, and children for whom you have been ordered by a court of law or through administrative order to provide health care coverage, and are dependent upon you for support

and maintenance. You may be required to provide documentation for proof of eligibility and a Power of Attorney is not considered court approval.

- Children of domestic partners if the child is primarily dependent upon the employee or domestic partner for support and one or both of the domestic partners is the biological parent of the child, adoptive parents of the child, or the child has been placed in the domestic partners' household as part of an adoptive placement, legal guardianship, or court order (with the exclusion of foster children).
- Children for whom you are legally responsible to provide health care coverage under a *qualified medical child support order* (A **qualified medical child support order** is a judgment, decree, or order — including approval of a settlement agreement — that states you are legally responsible to provide health care coverage for that child.)
- Unmarried children who were enrolled as dependents before age 25. However, the attainment of such age shall not terminate the coverage under the Plan of a dependent unmarried child who is incapable of self-sustaining employment because of mental or physical impairment if they are chiefly dependent upon you for maintenance and support. You must provide proof of the child's incapacity and dependency within 31 days of the child reaching age 25, and every year after that upon request by the Plan.

Eligible dependents shall not include extended family members such as parents, and other dependent relatives; e.g. aunts, uncles, and cousins, are not eligible under any circumstances. A court order to provide coverage for the extended family member does not require the State to grant eligibility to that dependent.

If you have questions about your child's eligibility, contact your agency group representative for details and forms.

During initial enrollment, proof of incapacity and dependency must be furnished by you to your agency group representative. Thereafter, proof of incapacity and dependency may be requested periodically by the Claim Administrator.

A dependent, other than your spouse, who is eligible under this Plan as an employee, that is also employed by the State of New Mexico or a participating Local Public Body, is not eligible for coverage as a dependent. If more than one parent is insured under this Plan as an employee, the dependent children may be enrolled as dependents of only one parent.

It is your responsibility to notify your agency group representative, who will then notify the Claim Administrator, of any change in your coverage status, including a name or address change.

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

Enrolling For Coverage

You must complete and return an enrollment form within 31 days of your eligibility date. If you don't elect coverage within 31 days of your eligibility date and later want coverage, you must wait until the next open enrollment period or enroll as a late applicant and be subject to the pre-existing condition limitation found later in this section – unless you have a qualified change in status or you are

eligible as a result of a special enrollment event. If you or an eligible dependent choose to waive coverage when initially eligible, you must complete a "Waiver of Coverage" form. If you (or your dependent) decline coverage due to having other coverage available, and later involuntarily lose the other coverage without having submitted a "Waiver of Coverage" indicating your reason for declining coverage, you (or the affected dependent) will not be eligible for a special enrollment.

If you have a qualified change in status or special enrollment event, you will be able to elect coverage within 31 days of the change. If you do not enroll within 31 days, you must wait until the next open enrollment period or enroll as a late applicant and be subject to the pre-existing condition limitation found later in this section.

Once you complete an enrollment form, your elections remains in effect through the Plan year – from July 1 to June 30. Each year you will have an opportunity to change your group health plan elections. The choice is effective the following July 1. You and your dependents will be automatically re-enrolled in the Plan each year unless you complete a new enrollment form changing your election during the enrollment period.

How to Enroll Dependents

You may apply for coverage of your eligible dependents, which may mean changing from Employee only coverage to Two-Party or Family coverage. Each additional dependent added to your coverage is subject to the pre-existing condition limitation, except:

- For a newborn child, you need to apply for dependent coverage before or within 31 days of the birth and the pre-existing condition limitation will not apply. However, if you do not apply for coverage for your newborn child within 31 days of birth when Family coverage is not in effect on the date of birth, coverage will be effective 90 days after the employee signs the enrollment application and a one (1) year pre-existing condition limitation will apply to Nonpreferred Provider services (unless eligible for a "special enrollment" as described later in this section).
- Newly adopted children are effective on the date of placement and must be enrolled within 31 days of that date. If you do not apply for coverage for your adopted child within 31 days of placement in the home or adoption, coverage will be effective 90 days after the employee signs the enrollment application and a one (1) year pre-existing condition limitation will apply to Nonpreferred Provider services (unless eligible for a "special enrollment" as described later in this section).

When Coverage Starts

If you enroll on or before the day you become eligible, your coverage becomes effective the day you are eligible. If you enroll within 31 days of becoming eligible, your coverage becomes effective on the day that you enroll or the first day of the following pay period.

- If you are an eligible employee paid on a biweekly basis, you are eligible for this Plan on the first day of the third full pay period following your date of employment.
- If you are an eligible employee paid on a monthly basis, you are eligible for this Plan on the first day of the month coinciding with or following completion of one month of employment.
- If you are an eligible employee paid on a semi-monthly basis, you are eligible for this Plan on the first day or the fifteenth day of the month coinciding with or following completion of one month of employment.

Contact your agency group representative for further details.

Generally, eligible dependents become insured on the same day that the employee becomes insured. If enrolled after the employee's effective date as a late applicant, the dependent's coverage will be effective 90 days after the employee signs the enrollment application, unless the dependent is eligible for a "special enrollment" as described later in this section.

The Plan pays for covered services that a member receives on or after the effective date of coverage.

Late Applicant Provision

Initial enrollment eligibility date — A member's effective date of coverage or the first day of any waiting period imposed on the member by the employer, whichever is earlier. (For example, for a late enrollee, the initial enrollment eligibility date is the date he/she signed the enrollment application, which is also the beginning of the 90-day waiting period imposed for late application enrollment. For a person applying under a special enrollment provision, the initial enrollment eligibility date is the date he/she first became eligible for special enrollment, such as the date coverage was lost or the date the subscriber was married.)

Late applicants — Enrollees who did not apply within 31 days of being eligible, but chose to apply at a later date and have not had a qualified change in status or special enrollment event.

Pre-existing condition — A physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant within the **six-month** period before his/her initial enrollment eligibility date (the date the late applicant signed the enrollment application). Pregnancy and pregnancy-related diagnoses are **not** considered pre-existing conditions. The Claim Administrator and the State cannot use genetic information or require genetic testing in order to determine if a condition is pre-existing or to limit or deny coverage.

For any late enrollee whose situation is not described as a "special enrollment," the effective date of coverage will be delayed 90 days from the date the application is signed. Also, a **one-year** pre-existing conditions limitation, beginning on the date the employee signed the enrollment application for the late enrollee's coverage, will apply to the Nonpreferred Provider level of benefits.

Exception — A late applicant newborn or adopted child who was enrolled in any group health plan or other creditable coverage within 30 days of birth or adoption and who has not experienced any significant lapse of coverage (i.e., 63 or more days) prior to enrolling in this health plan is not subject to the 90-day waiting period or the pre-existing conditions limitation.

Reduction in Waiting Period — The pre-existing conditions waiting period for Nonpreferred Provider services will be reduced for any member who had comprehensive medical/surgical coverage that was either still in effect, or was terminated within 63 days of, his/her initial enrollment eligibility date under this Plan. The waiting period will be reduced by at least the length of time he/she was continuously covered under the prior plan.

You can add up any creditable coverage you had prior to enrollment in this Plan, but if you went for 63 days or more without any creditable coverage (excluding any excepted time periods outlined below), the coverage you had before the break

will not be counted. Proof of such prior coverage (e.g., Certificate of Creditable Coverage) from your prior individual medical plan or group medical plan, including Medicaid, must be provided as supportive documentation.

What is Not Considered a Break in Coverage — For purposes of determining any significant break in coverage (i.e., 63 or more days), lapses in coverage due to any of the following situations will not be considered as part of a break:

- a waiting period imposed by a group health plan before it allowed you to become eligible for enrollment, and
- the amount of time between the date you submitted a substantially complete application for individual plan coverage and either the date the coverage began (if you were accepted), or the date on which the application was denied or on which the offer of coverage lapsed (if you were not accepted)
- the period of time between loss of coverage and COBRA election for certain workers whose employment was adversely affected by international trade and who were entitled to a second COBRA election period as a result

For any employee who lost coverage due to military service (and his/her eligible dependents), was re-employed under the provisions of the USERRA of 1994, and applied for reinstatement of coverage according to the timeliness limitations of the USERRA of 1994, the pre-existing conditions waiting period will continue to be credited during the time the employee is in military service.

The Limitation — For 12 months following the late enrollee's initial enrollment eligibility date (or nine months following his/her effective date of coverage), benefits for Nonpreferred Provider services that are related to any pre-existing condition limitation are limited to a **$1,000 maximum benefit,** which is then subject to applicable copayments, deductibles, and coinsurance provisions. After the pre-existing condition limitation time period is satisfied, regular Plan coverage provisions apply to Nonpreferred Provider services without any pre-existing condition limitation. **Pre-existing condition limitations apply only to the Nonpreferred Provider benefit level.**

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan. You must request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption, or placement for adoption.

If you have any questions about this law, contact your agency group representative.

Changing Your Coverage

Once you elect coverage, you generally cannot change your elections until the following open enrollment period. However, there are certain circumstances when you may be eligible to change coverage earlier. You must request the change in coverage within 31 days of the event causing the change. Any change must be consistent with the reason the change was permitted.

- Situations governed by HIPAA special enrollment rules.
- You, your spouse, or your dependent children become eligible for COBRA continuation coverage.
- Judgment, decree, or order that requires accident or group health coverage for your child.
- You, your spouse, or dependent children become entitled to Medicare or Medicaid. (You may cancel coverage for the individual who becomes eligible for Medicare or Medicaid coverage.)
- A significant cost or coverage change in the health care provided to you or your dependents through a third party, such as your spouse's employer.
- Change in status event, but only when the change causes you or your dependent to gain or lose eligibility for coverage. The change must correspond with the gain or loss of coverage
- A domestic partner achieves the 12-month eligibility requirements defined on page 16.

Note: It is your responsibility to notify your agency group representative, who will then notify the Claim Administrator, of any change in your coverage status, including a name or address change.

Family or Employment Status Changes (Qualifying Events)

You may make certain changes to your benefit elections within 31 days of a change in family/employment status. Evidence of a change in family/employment status must be provided to your agency group representative in order to change your benefit elections. Any change in coverage must correspond with the gain or loss of coverage and will become effective on the first pay period following the date the new benefit elections are made. The only exceptions would be birth and adoption, where the additional coverage would take place immediately upon enrollment. The following family/employment status changes are recognized by the State of New Mexico:

- marriage or divorce
- legal separation
- domestic partnership established or terminated
- birth or adoption of a child
- death of a spouse or dependent child
- a change in your spouse's employment (loss of job, or a new job that provides health care coverage, however, annual enrollment for a spouse's plan is not a family status change)
- a change in legal responsibility for a child
- the 25th birthday of a dependent child
- marriage of a dependent child
- change in employment status (regular part-time to regular full-time or vice versa)

Special Enrollment/Notice of Employee Rights

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you are declining enrollment for yourself or your dependents (including your spouse and eligible children) because of other group health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan.

You must request enrollment within 31 days after you or an eligible dependent lose coverage under another group health plan (or **within 31 days** of receiving the first denial notice informing the applicant that he/she has reached a lifetime benefit limit) either because:

- eligibility ends through no fault of their own, such as because of loss of employment or reduction in hours, change in job status, death of a spouse, or divorce or legal separation from a spouse, or the affected member reaches a lifetime maximum under the prior plan,
- COBRA benefits are exhausted,
- you return to work after serving active military/reserve duty,
- moving out of an HMO service area,
- if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option, and no substitute plan was offered, or
- employer contributions end (even if the affected member continues such coverage by paying the amount previously paid by the employer).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Rehires/Reinstatement of Coverage

If you terminate employment and then you are subsequently rehired within one year after termination, coverage can be reinstated without a waiting period or pre-existing condition exclusion. New applications must be completed within 31 days or you will be treated as a late enrollee. If reinstatement occurs in the middle of a pay period, coverage will be effective either the date eligible or the first day of the next pay period.

Coverage must be reinstated with the **exact same coverage and benefits** for which you were enrolled prior to termination. If your prior plan design was terminated during the time you were not covered, you must re-enroll in a currently offered plan that is most similar to the plan under which you were previously covered. You cannot add any coverages or benefits and still take advantage of immediate reinstatement privileges. If you want additional coverages, you will be treated as a newly hired employee even if you have had a change in family status.

ID Card

Your Plan ID card identifies the cardholder and your PPO coverage. Carry it with you. When you present your card to preferred providers, they know that you receive special benefits – they will file claims for you and will obtain any needed admission review or other prior approvals. You are responsible for any copayments, coinsurance, or expenses for noncovered services.

On your card is your member identification number and your group number. When contacting a BCBSNM customer service representative, always refer to your identification and group numbers. If you want additional cards or need to replace a lost card, contact a BCBSNM customer service representative.

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

How Coverage Stops

Coverage under this Plan terminates on the last day of the earliest of:

- the period for which premiums are paid;
- on the date when eligibility ceases; or
- when this Plan ends.

If you are enrolled in the State of New Mexico Premium Only Plan (POP), coverage can be dropped only with an approved change in family status. (See "Family or Employment Status Changes (Qualifying Events)" for details.)

If a dependent becomes ineligible due to age, coverage ceases on the applicable birthday.

If a dependent loses eligibility due to marriage, divorce, or dissolution of domestic partnership, coverage ends on the date of marriage, divorce, or dissolution.

Coverage under this Plan does not end for any member who is a hospital inpatient at the time of the membership termination until benefits applicable to the admission are exhausted or until the member is discharged from the hospital, whichever occurs first.

How to Disenroll Dependents

When you lose a dependent through marriage, death, divorce, annulment, or legal separation, or a dependent is ineligible due to age, please submit an application to disenroll the dependent from your coverage. Contact your agency group representative for the necessary forms.

Certificate of Coverage

If your coverage is terminated, the Claim Administrator provides evidence of your prior health coverage by supplying you with a Certificate of Coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for a pre-existing condition or if you want to buy, for you or your family, an individual insurance policy.

Leave Without Pay

Employees on leave without pay and employees with less than 27 hours of paid time on a biweekly pay period must pay the full premium to keep this coverage in force. The State makes no contribution in these instances. Premium payment must be made on the payday of that current pay period. Failure to pay premiums on the due date while on leave without pay will result in cancellation of coverage. If coverage is dropped or terminated while you are on leave without pay, you are subject to the late applicant provisions, except employees who are called to active military/reserve duty. It is extremely important to pay close attention to this requirement so that coverage is not lost. Please make prompt arrangements with your agency group representative.

Leave without pay guidelines apply to authorized leaves of absence, disability leaves, or temporary layoffs. If an employee is laid off, coverage may continue for three months, subject to extensions. If an employee is given a leave of absence,

coverage may continue for the full time of the leave of absence, not to exceed one year. If an employee is disabled, coverage may continue for up to one year from the date of disability. See your agency group representative for further information.

Continuation of Coverage Under the Family and Medical Leave Act (FMLA)

If you take a leave of absence that qualifies as a Family and Medical Leave under the Family and Medical Leave Act of 1993 (an "FMLA" leave), medical coverage for you and your family members continues as long as you continue paying your portion of the cost of coverage during the FMLA leave. Your agency group representative will advise you of the methods available to continue paying for your coverage. If you elect to discontinue medical coverage during an FMLA leave and subsequently return to work, your coverage will be reinstated with no waiting period or pre-existing condition limitation. For additional information on FMLA leave and the effect on your benefits, please contact your agency group representative.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The State of New Mexico supports voluntary military service with the United States armed forces and complies with all laws that protect your rights to benefits during or following a period of military service. If you leave the State of New Mexico employment to serve in a branch of the United States armed forces, you may be eligible to apply for reemployment in conformance with the Uniformed Services Employment and Reemployment Rights Act of 1994, and any amendments thereto. Contact your agency group representative to discuss your rights under this law.

Continuation of Coverage Under COBRA

This Plan is subject to the provisions for continuation of plan coverage under federal law (COBRA). The employee and his/her covered dependents who lose eligibility under this Plan may continue as group members for a limited period of time. (This provision is not applicable to domestic partners or their children.)

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

If you are an employee of the State of New Mexico covered by this health care plan, you have the right to choose this continuation coverage if you lose your group health coverage due to a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct).

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

- death of your spouse;
- termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- divorce or legal separation from your spouse; or
- your spouse becomes entitled to Medicare benefits.

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

- death of the parent employee;
- termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer;
- parent's divorce or legal separation;
- the dependent ceases to be a dependent child under the Plan; or
- the parent employee becomes entitled to Medicare.

Under this law, the employee or a family member has the responsibility to inform the Plan Administrator (your agency group representative) of a divorce, legal separation, or a child losing dependent status under the group plan.

A COBRA qualifying event also occurs upon an employee's death, termination of employment, any reduction in hours that disqualifies the person for group coverage, or Medicare entitlement (in the case of terminating employees only).

Should one of the above events have occurred, the Plan Administrator will in turn notify you (within 14 days of receipt of notification) that you have the right to choose continuation of coverage. Under this law, you have at least 60 days from the date you would lose coverage due to one of these events to inform the Plan Administrator that you want continuation of coverage.

If you do not choose continuation of coverage, your group health coverage will end.

If you choose continuation of coverage, your employer is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. This law requires that you be given the opportunity to maintain continuation of coverage for up to 36 months, unless:

- you lost group health care coverage due to a termination of employment or reduction in hours, in which case the required continuation coverage period is 18 months, or
- you have been determined to be disabled under the Social Security Act, in which case the required continuation coverage period is 29 months.

However, this law also provides that your continuation coverage may be cut short for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees.
- The premium for your continuation coverage is not paid on time.
- You become covered under another group health plan as a result of employment or re-employment (whether or not you are an employee of that employer),

unless the new plan contains an exclusion or limitation relating to any pre-existing condition you may have.
- You are a widow or were divorced from a covered employee and subsequently remarry and are covered under your new spouse's health plan unless the new plan contains an exclusion or limitation relating to any pre-existing condition you may have.
- You become entitled to Medicare benefits (coverage may continue for your spouse).
- You are determined to no longer be disabled (shortens the extended period).

You do not have to show that you are insurable to choose continuation coverage. However, under this law, you may have to pay 102 percent (150 percent in the case of the 19th through 29th month for a disabled person) of the full premium for your continuation coverage.

For more information regarding COBRA, contact your agency group representative.

COBRA and the Family and Medical Leave Act (FMLA)

A leave that qualifies as a Family and Medical Leave under the FMLA does not make you eligible for COBRA coverage. However, whether or not you lose coverage because of nonpayment of premiums during a Family and Medical Leave, you may be eligible for COBRA on the last day of the leave, which is the earliest of:
- the date you unequivocally inform your agency group representative that you are not returning at the end of the leave;
- the date your leave ends, assuming you do not return; or
- the date the FMLA entitlement ends.

For purposes of a Family and Medical Leave, you will be eligible for COBRA only if:
- you or your dependent is covered by the Plan on the day before the date the leave begins (or becomes covered during the leave); and
- you do not return to employment at the end of the leave; and
- you or your dependent loses coverage under the Plan before the end of what would be the maximum COBRA continuation period.

4 Covered Services

This section describes the services and supplies covered by this health care Plan, subject to the limitations and exclusions in *Sections 2* and *5*. All payments are based on covered charges as determined by BCBSNM, subject to rights of appeal as outlined in *Section 7*. **Reminder:** It is to your financial advantage to receive care from PPPs and other preferred providers.

See the Summary of Benefits for copayments, deductibles, and coinsurance percentages.

Medically Necessary Services

Medically necessary — Health care services determined by a provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or 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 BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease. The practice guidelines used by BCBSNM define a service or supply as medically necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under the Plan, and is determined by BCBSNM's medical director (in consultation with a BCBSNM-preferred provider) to meet all of the following conditions:

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

All services must be eligible for benefits as described in this section and the *Summary of Benefits*, not listed as an exclusion, and except for covered preventive services, must meet all of the conditions of "medically necessary" as defined above in order to be covered. **Because a provider prescribes, orders, recommends, or approves a service does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion.** (When services are rendered by a nonpreferred provider, BCBSNM will determine medical necessity based on the criteria above.)

If you disagree with BCBSNM's decision regarding the medical necessity of any item or service, you may file a complaint. You may also request an external review of the BCBSNM decision at any time. See "Grievance Procedures" in *Section 7*.

Alternative Therapy (Acupuncture, Biofeedback, Chiropractic, Massage Therapy, Naprapathic and Rolfing)

Acupuncture — The use of needles inserted into the human 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 health.

Biofeedback services — Training and other necessary services (such as the use of special equipment) related to making certain bodily processes (e.g., heartbeats or brain waves) perceptible to the senses so they can be mentally controlled.

Chiropractic services — Any covered service or supply administered by a chiropractor acting within the scope of his/her licensure according to the standards in New Mexico or the state in which services are rendered.

Massage therapy services — Manipulation of tissues with the hand or an instrument for therapeutic purposes.

Naprapathic services — Any covered services of a licensed naprapathic, including hand manipulation of connective tissue, intended to release tension and restore structural balance.

Rolfing — A licensed service mark used for a system of muscle massage intended to serve both as physical and emotional therapy.

See "Chronic Pain Treatment" in Section 5 for additional biofeedback limitations.
See "Smoking/Tobacco Use Cessation," if applicable, for additional benefits.

Acupuncture — Acupuncture is covered when administered by a licensed provider acting within the scope of licensure. Benefits for acupuncture, including office visits, treatment, and acupuncture when used as an anesthetic, are limited to **$1500 per Plan year,** in combination with chiropractic, massage therapy, and rolfing services.

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

Services or supplies must be administered by a licensed physician or a Board Certified Biofeedback Therapist acting within the scope of his/her licensure and according to the standards in New Mexico or the state in which services are rendered.

Chiropractic Services — Chiropractic services by a licensed chiropractor for the treatment of an illness or accidental injury are covered. Benefits are limited **$1500 per Plan year,** in combination with acupuncture, massage therapy, and rolfing services.

Massage Therapy — Benefits for medically necessary massage therapy that is prescribed by a physician for the treatment of an accidental injury or other pain are limited as specified on the *Summary of Benefits,* in combination with acupuncture, chiropractic, and rolfing services. Services must be administered by a licensed massage therapist acting within the scope of his/her licensure and

according to the standards in New Mexico or the state in which services are rendered.

Naprapathic Services — Naprapathic services by a licensed naprapath for the treatment of an illness or accidental injury are covered. Benefits are limited **$1500 per Plan year.**

Rolfing — Rolfing is covered, limited **$1500 per Plan year,** in combination with acupuncture, massage therapy, and chiropractic services. Services must be administered by a licensed rolfer acting within the scope of his/her licensure and according to the standards in New Mexico or the state in which services are rendered.

See Section 5: General Limitations and Exclusions

Ambulance Services

Ambulance — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

See "Emergency and Urgent Care" for details on obtaining emergency care.

When you cannot be safely transported by any other means in a nonemergency situation, this Plan covers medically necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another. The Plan also covers ambulance services in an emergency (e.g., cardiac arrest, stroke).

Air Ambulance — This Plan covers air ambulance only when terrain, distance, or your physical condition requires the use of air ambulance services, or for high-risk maternity and newborn transport to tertiary care facilities.

BCBSNM determines, on a case-by-case basis, when air ambulance is covered. If BCBSNM determines that ground ambulance services could have been used, benefits are limited to the cost of ground ambulance services. Nonemergency air transport is covered only if transfer to another facility is medically necessary to protect the life of the patient. It is recommended that you request prior approval **before** securing the services of any air transportation provider in order to verify that the service is medically necessary and will be covered.

See Section 5: General Limitations and Exclusions

Dental-Related/TMJ Services

Accidental injury — A condition that is not the result of illness but is caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection. Dental injury caused by chewing, biting, or malocclusion is **not** considered an accidental injury.

Dental-related services — Services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Sound natural teeth — Teeth that are whole, without impairment, without periodontal or other conditions, and not in need of treatment for any reason other than

the accidental injury. Teeth with crowns or restorations (even if required due to a previous injury) are **not** sound natural teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. (Your provider must submit x-rays taken *before* the dental or surgical procedure in order for BCBSNM to determine whether the tooth was "sound.")

For oral surgery benefits, see "Surgery and Related Services."

The following services are the only dental services covered under this Plan. Benefits are based upon the least costly, medically appropriate procedure or device available.

Dental and Facial Accidents — Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are subject to the same limitations, exclusions, and member cost-sharing requirements that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical procedures).

To be covered, *initial* treatment for the injury must be sought **within 72 hours** of the accident. Any services required after the initial treatment must be received **within two years** of the date of accident in order to be covered (unless treatment must be delayed due to dental necessity as determined by BCBSNM).

Facility Charges and General Anesthesia for Dental-Related Services — This Plan covers inpatient or outpatient hospital expenses (including ambulatory surgical centers) and hospital and physician charges for administration of general anesthesia for noncovered, medically necessary dental-related services if the patient requires hospitalization for one of the following reasons:

- Because of the **patient's** physical, intellectual, or medical condition(s), local anesthesia is not the best choice.
- Local anesthesia is ineffective because of acute infection, anatomic variation, or allergy to local anesthesia.
- The patient is a member age 19 or younger who is extremely uncooperative, fearful, or uncommunicative; his/her dental needs are too significant to be postponed; and lack of treatment will be detrimental to the child's dental health.
- Because oral-facial or dental trauma is so extensive, local anesthesia would be ineffective.
- There is a medically necessary dental procedure – not excluded by any *General Limitation or Exclusion* listed in the benefit booklet such as for work-related, pre-existing, or cosmetic services, etc. – that requires the patient to undergo general anesthesia or be hospitalized.

All hospital services for dental procedures must be **prior-approved** by BCBSNM. **Note:** Unless listed as a covered procedure in this section, the dentist's services for the procedure will not be covered. **Reminder:** If hospital services are recommended by any out-of-network provider, you are responsible for obtaining **admission review approval** for the admission or **prior approval** for outpatient services to receive maximum benefits. (See "Admission Review and Other Prior Approvals" in *Section 2*.)

This Plan does **not** cover:

- surgeon's or dentist's charges for the noncovered dental-related service
- hospitalization or general anesthesia for the patient's or provider's convenience

- any service related to a dental procedure that is not medically necessary or that is excluded under this plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, services related to pre-existing conditions, work-related injuries, etc.)

TMJ/CMJ Services — This Plan covers standard diagnostic, therapeutic, surgical, and nonsurgical treatments of temporomandibular joint (TMJ) or craniomandibular joint (CMJ) disorders or injuries. Covered services may include orthodontic appliances and treatment, crowns, bridges, or dentures **only if** services are required because of an accidental injury to sound natural teeth involving the temporomandibular or craniomandibular joint.

Exclusions — This Plan covers only those procedures listed above. This Plan does **not** cover any other oral or dental procedures such as, but not limited to:

- nonstandard services (diagnostic, therapeutic, or surgical)
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under "Dental and Facial Accidents" or "TMJ/CMJ Services"
- removal of impacted teeth; dental services needed due to a medical condition or a medical or surgical procedure (e.g., chemotherapy or radiation therapy); removal of tori or exostoses; procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures
- duplicate or "spare" appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- artificial devices and/or bone grafts for denture wear

See Section 5: General Limitations and Exclusions

Diabetic Services

For insulin and over-the-counter diabetic supplies, refer to Express Scripts.
For durable medical equipment and supplies, see "Supplies, Medical Equipment, and Prosthetics."
For educational services and diabetes management services, see "Physician Visits/Medical Care."

Diabetic members are entitled to the same benefits for medically necessary covered services as are other members under the health care plan. For special coverage details, such as for insulin, glucose monitors, and educational services, see the above topics. **Note:** The Plan will cover items not specifically listed as covered when new and improved equipment, appliances, and prescription drugs for the treatment and management of diabetes are approved by the United States Food and Drug Administration.

See Section 5: General Limitations and Exclusions

Emergency and Urgent Care

Emergency care — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement.

Urgent care — Medically necessary medical or surgical procedures, treatments, or services received for an unforeseen condition that is not life-threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

For accidental injury to the mouth, jaw, teeth, or TMJ, see "Dental-Related/TMJ Services."

Also see other subheadings in this section when applicable (such as "Hospital/Other Facility Services").

Emergency Care

Acute medical emergency care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition must meet the definition of an "emergency" in order to be covered. If **emergency** room treatment is administered by either a preferred or nonpreferred provider, benefits for the **initial** treatment are subject to the copayment provisions listed on the *Summary of Benefits*. If you are hospitalized within 48 hours of an emergency, the entire, related hospitalization is considered part of the initial treatment.

If you are directly admitted as an inpatient, the emergency room copayment is waived and hospital inpatient benefits apply to covered facility services. **Note:** Services received in an emergency room that do not meet the definition of an "emergency" may be reviewed for appropriateness and may be denied.

Reminder: If you are admitted because of an emergency, BCBSNM must be called **within 48 hours** of the admission or benefits for covered facility services will be **reduced by $300.** See "Admission Review and Other Prior Approvals" in *Section 2*.

Covered services for nonpreferred provider **follow-up** care, including services received from a nonpreferred provider after you are discharged from the hospital or emergency room, are paid at the Nonpreferred Provider benefit level.

Urgent Care

When you visit a preferred urgent care facility, you pay only a fixed-dollar amount, or copayment, for the covered services after your annual deductible is met. The copayment **does** include other covered services received at the time of the visit (e.g., lab work or medical supplies). When you visit a nonpreferred urgent care facility, covered services are subject to deductible and coinsurance.

See Section 5: General Limitations and Exclusions

Family Planning and Infertility

For oral contraceptive coverage, refer to Express Scripts.

Note: Like benefits for most other conditions, member cost-sharing amounts are based on the place of treatment (e.g., outpatient hospital vs. inpatient hospital) and the type of service received (e.g., diagnostic test vs. surgical procedure).

Covered Services — Covered family planning services are limited to:
- injection of Depo-Provera for birth control purposes
- diaphragm, including fitting
- IUDs or cervical caps, including fitting, insertion, and removal
- surgical sterilization procedures such as vasectomies and tubal ligations

This Plan covers the following infertility-related treatment and testing services (note that the following procedures only *secondarily* also treat infertility):
- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is **not** the result of a surgical sterilization
- replacement of deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced

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

Exclusions — This Plan does **not** cover:
- sterilization reversal for males or females
- Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization
- artificial conception or insemination, including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro ("test tube") fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception
- services not listed as covered, including oral contraceptives and over-the-counter contraceptive products such as condoms and spermicide

See Section 5: General Limitations and Exclusions

Home Health Care/Home I.V. Services

Home health care services — Covered services, as listed below, that are provided in the home according to a treatment plan by a certified home health care agency under active physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient's physician.

For oxygen, ostomy supplies, and medical equipment, see "Supplies, Equipment, and Prosthetics."

Conditions and Limitations of Coverage — If you are homebound (unable to receive medical care on an outpatient basis), home health care and home I.V. services are covered. Benefits are limited as specified on the *Summary of Benefits.* Services must be provided under the direction of a physician and nursing management must be through a home health care agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours.

Prior Approval Required — Before you receive home health care or home I.V. therapy, you, your physician, or home health care agency must obtain **prior approval** from BCBSNM.

Covered Services — This Plan covers the following services, subject to the limitations and conditions above, when provided by an approved home health care agency during a covered visit in your home:

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician (If *not* provided by the home health agency or if products do not require a prescription, contact Express Scripts.)
- medical supplies
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **prior approval** is received from BCBSNM (If drugs are *not* provided by the home health agency, contact Express Scripts.)
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions — This Plan does **not** cover:

- care provided primarily for your or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See "Custodial Care" in *Section 5*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription parenteral and enteral nutritional products (Refer to Express Scripts regarding benefits for these products.)

See Section 5: General Limitations and Exclusions

Hospice Care

Hospice benefit period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends six months after the period began (or upon the member's death, if sooner). The hospice benefit period must begin while the member is covered for these benefits, and coverage must be maintained throughout the hospice benefit period.

Terminally ill patient — A patient with a life expectancy of six months or less, as certified in writing by the attending physician.

Conditions and Limitations of Coverage — This Plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM. Hospice care benefits are limited as specified on the *Summary of Benefits.*

If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM. No more than two hospice benefit periods will be approved. **Note:** An extension of the hospice benefit period does **not** increase the total amount of benefits payable under this provision for respite care and bereavement counseling.

Prior Approval Required — Before you receive hospice care, you, your attending physician, or the hospice agency must request **prior approval** from BCBSNM.

Covered Services — This Plan covers the following services, subject to the limitations and conditions above, under the hospice care benefit:

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see "Supplies, Equipment, and Prosthetics.")
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, contact Express Scripts.)
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- two respite care periods for up to a maximum of **ten days each** during the six-month hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)
- bereavement counseling provided by an M.S.W. or M.A. for immediate family members if ordered and received under the hospice program during a hospice benefit period or within three months of the death of the member covered under this Plan (A maximum of **three counseling sessions** will be covered.)

Exclusions — This Plan does **not** cover:

- food, housing, or delivered meals
- volunteer services
- medical transportation
- homemaker and housekeeping services; comfort items
- private duty nursing
- pastoral or spiritual counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan

The following services are **not** hospice care benefits but may be covered elsewhere under this Plan: acute inpatient hospital care for curative services, durable medical equipment, physician visits unrelated to hospice care, and ambulance services.

See Section 5: General Limitations and Exclusions

Hospital/Other Facility Services

If applicable, see:
"Dental-Related/TMJ Services"
"Emergency and Urgent Care"
"Hospice Care"
"Maternity Services"
"Mental Health and Substance Abuse"

See other subheadings in this section that apply to the type of service required, such as "Surgery and Related Services" or "Transplant Services."

Blood Services

This Plan covers the processing, transporting, handling, and administration of blood and blood components. This Plan covers directed donor or autologous blood storage fees only when the blood is used during a scheduled surgical procedure. This Plan does **not** cover blood replaced through donor credit.

Inpatient Services

Admission — The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date. Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Plan.)

For inpatient physician medical visits, including newborn care, see "Physician Visits/Medical Care."

Admission Approval Required — If hospitalization is recommended by a nonpreferred provider, **you are responsible** for obtaining admission approval. Also, you must obtain approval if you are transferred from one inpatient facility to another or re-admitted to a facility for any reason. If your covered newborn stays in the hospital longer than the mother, BCBSNM should be called before, or as soon as reasonably possible following, the mother's discharge.

If approval is not obtained, benefits for covered facility services may be **reduced or denied** as described under "Admission Review and Other Prior Approvals" in *Section 2*. Noncovered services will be denied.

Emergency or Pregnancy-Related Admissions — You must notify your BCBSNM **within 48 hours** of an emergency admission (or as soon as reasonably possible). If approval is not obtained from BCBSNM for emergency admissions within 48 hours (or as soon as reasonably possible), benefits for covered facility services may be **reduced by $300.**

For pregnancies, you should call before your maternity due date, soon after your pregnancy is confirmed. You are responsible for making sure that BCBSNM is notified **within 48 hours** of admission for a routine delivery or within 96 hours

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for a C-section delivery (or as soon as possible). If not notified within this time period and your admission extends beyond 48 hours or 96 hours (as applicable), benefits for covered facility services will be reduced by **$300.** See "Admission Review and Other Prior Approvals" in *Section 2*.

Appeals — If you disagree with BCBSNM's decision regarding the medical necessity of an admission, you may file a complaint. You may also request an external review of the BCBSNM decision at any time. See "Grievance Procedures" in *Section 7*.

Covered Services — For care received during a covered hospital or physical rehabilitation facility admission, this Plan covers semiprivate room or special care unit (e.g., ICU, CCU) expenses and other medically necessary services provided by the facility. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. BCBSNM must give **prior approval** for medically necessary private room charges to be covered. See "Admission Review and Other Prior Approvals" in *Section 2*.) If you are admitted to a hospital or other treatment facility within 15 days of a related hospitalization in another acute care facility, no additional preferred provider copayment is required for the second admission's services.

Medical Detoxification — This Plan also covers medically necessary room expenses and ancillary services related to medical detoxification from the effects of alcoholism or drug abuse (usually limited to three days). The usual medical/surgical benefit applies to such services. (Benefits for rehabilitation are described under "Mental Health and Substance Abuse.")

Newborn Care — If you have coverage for your newborn child (see *Section 3* for details about enrolling your newborn), the initial routine newborn care is covered. **Note:** If the parent of the newborn is a dependent child of the subscriber (i.e., the newborn is the grandchild of the subscriber), services for the newborn are **not** covered, unless the newborn is added to coverage as an eligible dependent according to the provisions of *Section 3*.

If the mother's charges are eligible for coverage under this Plan, no deductible or coinsurance and no additional hospital copayment is required for the initial routine nursery and pediatrician care if the covered newborn is discharged on the same day as the mother.

Extended Stay Newborn Care: A newborn who is enrolled for coverage within the time limits specified in *Section 3* is also covered if he/she stays in the hospital longer than the mother. An additional hospital copayment **is** required in such cases.

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If the child's pediatrician is *not* a preferred provider, you must also ensure that BCBSNM is called **before** the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services will be reduced by **$300.** The baby's services will be subject to a separate deductible, coinsurance, and out-of-pocket limit.

Physical Rehabilitation — This Plan covers inpatient rehabilitation services that are medically necessary to restore and improve lost function following accidental injury or illness.

To be covered, all admissions must receive admission review approval from BCBSNM before admission or benefits for covered services may be **reduced by $300.** Hospitalization for rehabilitation must begin within one year after the onset of

the condition and while you are covered under this Plan. Inpatient treatment must be medically necessary and not for personal convenience.

This Plan also covers therapy required due to reinjury or aggravation of an injury but must the admission must receive a separate approval from BCBSNM, even if therapy was authorized for the original injury. To be eligible for benefits, therapies must meet the following conditions:

- There is a documented condition or delay in recovery that can be expected to improve with therapy.
- Improvement would not normally be expected to occur without intervention.

Skilled Nursing Facility Services — This Plan covers expenses incurred during a skilled nursing facility confinement after a hospital stay. The confinement must be recommended by the attending physician for the condition causing the hospitalization.

Covered expenses include the daily semiprivate room expenses and other medically necessary services provided by the facility. This benefit is limited as specified on the *Summary of Benefits* and is subject to continued stay review for medical necessity. If you are admitted to a preferred provider skilled nursing facility within **15 days** of a related hospitalization in an acute care facility, no additional preferred provider copayment is required for the skilled nursing facility services. You pay only the inpatient hospital copayment and related physician/professional provider charges. For nonpreferred provider admissions, you pay regular nonpreferred provider deductible and coinsurance.

Admission review approval is required for admissions or benefits for covered facility services will be reduced by **$300.**

Exclusions — This Plan does **not** cover:

- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws) and BCBSNM has given prior approval for such medically necessary charges
- admissions related to noncovered services or procedures (See "Dental-Related/ TMJ Services" for an exception.)
- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Plan does **not** cover services that are in excess of maximum benefit limitations. See the "Long-Term or Maintenance Therapy" exclusion in *Section 5.)*
- extended care facility admissions or admissions to similar institutions

Outpatient and Observation Services

Outpatient services — Medical/surgical services received in the outpatient department of a hospital, emergency room, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility.

Coverage for observation stays and for outpatient services depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services") or on special circumstances (for example, see "Emergency and Urgent Care"). If you are directly admitted into observation from an outpatient setting or emergency room, only one copayment is required for preferred provider care. If you are directly admitted from either the outpatient department or from observation as an inpatient, no copayment is required for the outpatient or observation services. In such cases, inpatient hospital benefits will apply.

Lab, X-Ray, Other Diagnostic Services

Diagnostic services — Procedures such as laboratory and pathology tests, x-ray services, EKGs, and EEGs that do not require the use of an operating or recovery room, and that are ordered by a provider to determine a condition or disease.

For services received during a covered inpatient admission, see "Hospital/Other Facility Services."
For allergy testing benefits, see "Physician Visits/Medical Care."
If applicable, also see these topics:
"Alternative Therapy" (for acupuncture, chiropractic, massage therapy, naprapathy, biofeedback, and rolfing)
"Dental-Related/TMJ Services"
"Preventive Services"
"Family Planning and Infertility"
"Transplant Services"
For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see "Surgery and Related Services."

This Plan covers the following diagnostic services, including preadmission testing, that are related to an illness or injury:

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness
- infertility-related testing (See "Family Planning and Infertility.")
- sleep disorder studies and bone density studies (If sleep studies must be performed on an inpatient basis, such as for sleep disorder studies, prior authorization is required and the usual hospital inpatient benefit will apply to covered services.)
- prenatal genetic testing and, when **prior-approved** by BCBSNM, home uterine monitoring (Tests such as amniocentesis or ultrasound to determine the sex of an unborn child are not covered; see "Maternity Services.")
- PET (Positron Emission Tomography) scans, with **prior approval** from BCBSNM

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All services, including those for which prior approval is required, must meet the standards of medical necessity criteria established by the Claims Administrator and will not be covered if excluded for any reason under this Plan. **Some services requiring prior approval will not be approved for payment.**

See Section 5: General Limitations and Exclusions

Maternity Services

See other subheadings in this section for services received during a covered pregnancy, such as "Lab, X-Ray Other Diagnostic Tests" or "Hospital/Other Facility Services."
For newborn care, see "Physician Visits/Medical Care" and "Hospital/Other Facility Services."

Under Two-Party or Family coverage, a covered dependent daughter also has coverage for maternity services. **Note:** If the parent of the newborn is a dependent child of the subscriber (i.e., the newborn is the grandchild of the subscriber), benefits are **not** available for the newborn, unless the newborn is added to coverage as an eligible dependent according to the provisions of *Section 3*.

Call Within 48 Hours
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If you are pregnant, you should call before your maternity due date, soon after your pregnancy is confirmed. In any case, you are responsible for making sure that BCBSNM is notified **within 48 hours** of admission for a routine delivery or within 96 hours for a C-section delivery (or as soon as possible). If not notified within this time period and your admission extends beyond 48 hours or 96 hours (as applicable), benefits for covered facility services will be reduced by **$300.** See "Admission Review and Other Prior Approvals" in *Section 2*.

The office visit during which a pregnancy is confirmed is subject to the office visit copayment listed on the *Summary of Benefits* if you choose a PPP as your maternity care provider; otherwise, usual benefits apply.

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Covered Maternity Services — Covered maternity services include:

- hospital or other facility charges for semiprivate room and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery.)
- pregnancy-related diagnostic tests, including genetic testing or counseling and, when **prior-approved** by BCBSNM, home uterine monitoring (Genetic testing services must be sought due to a family history of a sex-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that commonly increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the sex of an unborn child are not covered.)
- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife, or licensed midwife (Expenses for prenatal and postnatal care are included in the covered charge for the actual delivery or completion of pregnancy. In a preferred provider's office, the visit during which a pregnancy is confirmed is subject to the office visit copayment.)
- deliveries at home by an obstetrician, certified nurse-midwife, or a licensed midwife (Lay midwife deliveries are **not** covered. Also, home births are not covered at the preferred provider benefit level unless the provider is a preferred provider specifically contracted and credentialed to provide home birth services.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See "Ambulance Services" for details.)
- services of a physician who actively assists the operating surgeon in performing a covered procedure when the procedure requires an assistant
- spontaneous, therapeutic, or elective termination of pregnancy prior to full term (Copayments will be based on the place of treatment at the time of pregnancy termination.)

See Section 5: General Limitations and Exclusions

Medical Therapy (Cardiac and Pulmonary Rehabilitation, Chemotherapy, Radiation, Dialysis)

When billed by a facility during a covered admission, therapy is covered in the same manner as the other ancillary services (see "Hospital/Other Facility Services").

Chemotherapy and Radiation Therapy — Treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy is covered.

Cancer Clinical Trials — If you are a participant in a phase II, III, or IV approved "cancer clinical trial" (see *Glossary)* that is being conducted in New Mexico, you may receive coverage for certain "routine patient care costs" (see *Glossary)* incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection, or treatment or palliation of cancer. In order to be considered for possible coverage, the persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified clinical trial and must accept BCBSNM's covered charges as payment in full (this includes the Plan's payment plus your share of the covered charge).

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or provider of the drug. Member cost-sharing provisions described in your separately issued drug plan rider from Express Scripts will apply to these benefits.)

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

Cardiac and Pulmonary Rehabilitation — This Plan covers outpatient cardiac rehabilitation programs and outpatient pulmonary rehabilitation services.

Dialysis — This Plan covers the following services when received from a dialysis provider or in your home:

- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)
- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

See Section 5: General Limitations and Exclusions

Mental Health and Substance Abuse

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 3 to 12 hours of continuous psychiatric care in a treatment facility). Two partial days equal one full inpatient day.

Medical detoxification — Treatment for withdrawal from the physiological effects of substance abuse.

Outpatient services — Care provided by a professional provider, hospital, alcoholism treatment center, or other provider in the provider's office or the outpatient department of a hospital, alcoholism treatment center, or other facility, including facility-based intensive outpatient programs.

Other provider — Clinical psychologists and the following masters-degreed psychotherapists (an independently **licensed** professional provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level registered nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For substance abuse services, a provider also includes a licensed alcohol and drug abuse counselor (L.A.D.A.C.).

For admissions required for medical detoxification, see "Hospital/Other Facility Services."

Medical Necessity — In order to be covered, treatment must be medically necessary and not experimental or investigational. Therapy must be:

- required for the treatment of a distinct mental disorder as defined by the latest version of the *Diagnostic and Statistical Manual* published by the American Psychiatric Association; and
- reasonably expected to result in significant and sustained improvement in your condition and daily functioning; and
- consistent with your symptoms, functional impairments, and diagnoses, and in keeping with generally accepted national and local standards of care; and
- provided to you at the least restrictive level of care.

Inpatient and outpatient services, including residential treatment center and partial hospitalization services, must be **prior-approved** by Mesa Mental Health. See "Admission Review and Other Prior Approvals" in *Section 2*.

Exclusions — This Plan does **not** cover:

- any care that is patient-elected and is not considered medically necessary
- inpatient substance abuse or residential treatment center services that have not been approved by Mesa Mental Health prior to being admitted (For inpatient mental health services that do not receive prior approval, benefits for covered facility services are reduced by $300.)
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental illness or other disturbances (See *Section 7* for reimbursement of certain services provided to eligible children by the Department of Health.)
- non-national standard or experimental therapies
- the cost of any damages to a treatment facility
- charges associated with any episode of alcoholism or drug abuse for which you did not complete the prescribed continuum of care
- substance abuse or residential treatment center services in excess of the annual or lifetime maximum benefits specified on the *Summary of Benefits*
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services performed or billed by a school, halfway house, group home, or their staff members; foster care, day treatment, or behavior modification services
- long-term therapy or therapy for the treatment of chronic mental health or incurable conditions for which treatment produces minimal or temporary

change or relief – except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down's Syndrome, and developmental delays. See *Section 7* for reimbursement of certain services provided to eligible children by the Department of Health.)
- maintenance therapy or care provided after you have reached your rehabilitative potential
- biofeedback or hypnotherapy (Hypnotherapy is covered only under the "Smoking/ Tobacco Use Cessation" benefit. Biofeedback is also covered under "Smoking/ Tobacco Use Cessation" and, in addition, for certain physical conditions. See "Alternative Therapy: Biofeedback" for details.)
- religious counseling; marital counseling
- custodial care (See the "Custodial Care" exclusion in *Section 5*.)
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation

Mental Health Services

Mental disorder, mental illness — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with solution-focused evaluative and therapeutic mental health services. Mental illness does not include developmental disabilities, drug or alcohol abuse, or learning disabilities.

Inpatient Treatments — **Prior-approved** room expenses and hospital ancillary services are covered. The benefit includes related physician visits received on a covered admission day. Outpatient and residential treatment center services are **not** covered under this "Inpatient Treatments" provision.

Prior approval from Mesa Mental Health is required for all inpatient admissions and/or partial hospitalization days, a **$300 benefit reduction** will apply to covered facility services. See "Admission Review and Other Prior Approvals" in *Section 2*.

Outpatient Services — This Plan covers medically necessary outpatient care, evaluation, diagnosis, and/or treatment of mental illness when services are rendered by psychiatrists, psychologists, licensed family therapists, and other providers (as defined earlier). Covered services include:
- solution-focused evaluative and therapeutic individual and group psychotherapy, including psychological testing
- evaluation of attention deficit disorders (ADD) or attention deficit with hyperactivity disorders (ADHD) **Note:** Based upon a review of the results, further medical treatment may be allowed if **prior approval** for such treatment is received from Mesa Mental Health.

Inpatient, partial hospitalization, and residential treatment center services are **not** covered under this "Outpatient Services" provision.

Substance Abuse Rehabilitation

Substance abuse — A condition defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol and/or other drugs. There may also be significant risk of severe withdrawal symptoms if the use of alcohol, drug, or other substance is discontinued. Drug

abuse does not include the abuse of alcohol or nicotine addiction. Substance abuse may also be referred to as "chemical dependency."

Covered services include treatment received in an alcoholism treatment program that complies with the Alcohol and Drug Abuse Program standards required by the state of New Mexico, hospitals, treatment facilities, and services rendered by psychiatrists, psychologists, licensed family therapists, and other providers (as defined earlier).

Inpatient Rehabilitation — **Prior-approved** room expenses and hospital ancillary services for the treatment of alcoholism and/or drug abuse are covered. Benefits for covered services are limited each Plan year as specified on your *Summary of Benefits*. The maximum benefit includes related physician visits received on a covered admission day.

Prior approval from Mesa Mental Health is required for all inpatient admissions and/or partial hospitalization days **or services will not be covered.** See "Other Prior Approvals" in *Section 2*. Outpatient and residential treatment center services are **not** covered under this "Inpatient Rehabilitation" provision.

Outpatient Rehabilitation — This Plan covers outpatient care, evaluation, diagnosis, and/or treatment of alcoholism and drug abuse. Benefits for covered services are limited each Plan year as specified on your *Summary of Benefits*. Inpatient, partial hospitalization, and residential treatment center services are **not** covered under this "Outpatient Rehabilitation" provision.

Substance Abuse Benefit Period Limitation — Benefits for substance abuse rehabilitation are also limited to those treatments you receive during a maximum of **two 12-month benefit periods (courses of treatment)** for as long as you remain covered under the Plan. Two courses of treatment are available for all inpatient, residential treatment center, and partial hospitalization services combined and two courses of treatment for all outpatient services, including intensive outpatient programs. Even if you have not exhausted your annual benefit, you will not be extended coverage beyond the two benefit periods to which you are entitled. The benefit periods need not be consecutive in order to be covered (as long as you maintain eligibility).

Minimum Coverage for Alcoholism Rehabilitation — If you exhaust your maximum benefits when receiving services that are *not* related to alcoholism, you are still entitled to up to 30 inpatient days and 30 outpatient/office visits for medically necessary alcoholism rehabilitation during each of two 12-month benefit periods. However, if you exhaust an *annual* 30-day or 30-visit Plan year maximum for substance abuse receiving alcoholism treatment, benefits for drug abuse treatment will not renew until the following Plan year, subject to the lifetime maximum benefit provision. Likewise, if you are receiving alcoholism treatment and use up your lifetime maximum benefit of two courses of treatment, no further drug abuse rehabilitation benefits are available.

If You Also Need Medical Care — The member cost-sharing provisions for medical services such as medical detoxification are different from those for behavioral health services. For example, if you are admitted for a medical condition and later transferred to another unit in the same or different facility for drug abuse rehabilitation (or vice versa) you must pay both admission copayments for preferred provider care.

Residential Treatment Center

Residential treatment center — An institution that specializes in the treatment of mental illness, alcohol or drug abuse, or other related illness, provides residential treatment programs and is licensed in accordance with the laws of the appropriate legally authorized agency.

Care must be prior-approved by Mesa Mental Health. Failure to obtain **prior approval** for will result in a denial of coverage. Benefits are limited as specified on the *Summary of Benefits*. Benefits for services in a residential treatment center are also subject to the benefit period limitation described under "Substance Abuse Rehabilitation," on page 43.

See Section 5: General Limitations and Exclusions

Physician Visits/Medical Care

If applicable, see these topics:
- *"Alternative Therapy" (acupuncture, chiropractic care, massage therapy, naprapathy, biofeedback, rolfing)*
- *"Dental-Related/TMJ Services"*
- *"Emergency and Urgent Care"*
- *"Family Planning and Infertility"*
- *"Home Health Care/Home I.V. Services" or "Hospice Care"*
- *"Maternity Services"*
- *"Mental Health and Substance Abuse"*
- *"Preventive Services"*
- *"Short-Term Rehabilitation (for inpatient and outpatient physical, occupational, and speech therapy, including skilled nursing facility admissions)*
- *"Smoking/Tobacco Use Cessation"*

This section describes benefits for nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment. See the topics referenced above for more information regarding a particular type of service. This Plan covers medically necessary care provided by a physician or other professional provider for an illness or injury. **Your choice of provider can make a difference in the amount you pay.** (See *Section 2*.)

Office Visits and Consultations

Covered services include office and home visits, FDA-approved therapeutic injections, consultations (including second or third surgical opinions), and examinations — when not related to hospice care or payable as part of a surgical procedure (see "Hospice Care" and "Surgery and Related Services").

Allergy Care — This Plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), covered charges for allergy serum, and appropriate FDA-approved allergy injections administered in a provider's office or in a facility. **Note:** When the patient is not seen by a physician and the injection is administered by a nurse, no office visit copayment will apply at the Preferred Provider benefit level.

Diabetic Services — If you have diabetes or an elevated blood glucose due to pregnancy, diabetes self-management training is covered. Training must be prescribed by a health care provider and given by a certified, registered, or licensed health care professional with recent education in diabetes management. Covered services are limited to:

- medically necessary visits upon the diagnosis of diabetes
- visits following a physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management
- visits when re-education or refresher training is prescribed by a health care provider
- medical nutrition therapy related to diabetes management

See "Supplies, Equipment, and Prosthetics" for benefits related to certain diabetic medical supplies and equipment. For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips for blood glucose monitors, glucagon emergency kits), call Express Scripts.

Genetic Inborn Errors of Metabolism — This Plan covers medically necessary health care expenses related to the diagnosis, monitoring, and control of genetic inborn errors of metabolism (defined in the *Glossary).* Covered services include related office visits, lab work, medical supplies, and corrective lenses. In order to be covered, services cannot be excluded under any other provision of this booklet, and you must be receiving medical treatment from licensed health care professionals, including physicians, dieticians, and nutritionists, who have specific training in managing patients with genetic inborn errors of metabolism.

Note: For prescription drug and special medical foods coverage, contact Express Scripts.

Injectable Drugs and Injections — Most FDA-approved therapeutic injections administered in a provider's office are covered. However, some injectable drugs are covered only when **prior approval** is received from BCBSNM. Your BCBSNM-contracted provider has a list of those injectable drugs that require prior approval. If you need a copy of the list, contact a BCBSNM Health Services representative. **Note:** When you request prior approval for an injectable drug, you may be directed to Express Scripts.

BCBSNM reserves the right to exclude any injectable drug currently being used by a member that is not specifically listed as covered. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Health Services representative if you have any questions about this policy.

Inpatient Medical Visits

For services related to an organ transplant, also see "Transplant Services."

See "How to Enroll Dependents" in Section 3 for details on adding newborns to your coverage.

With the exception of dental-related services (see "Dental-Related/TMJ Services"), benefits are available for the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care (See "Hospice Care.")
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care **not** related to the surgery (For the surgeon's services, see "Surgery and Related Services.")
- medical care requiring two or more physicians at the same time because of multiple illnesses

- initial routine newborn care (care of a child immediately following his/her birth that includes pediatrician standby care at a C-section and circumcision of a male newborn) for a newborn added to coverage within the time limits specified in *Section 3* (See "Hospital/Other Facility Services" for extended stay benefits.)

See Section 5: General Limitations and Exclusions

Preventive Services

Claims filed under this provision must clearly show that the office visit and tests were for routine or preventive care.

The services listed below are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult). You and your physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your health care plan. **Note:** Covered routine and preventive services, including related lab, x-ray, and other tests are paid at 100 percent of the covered charge when received from a **preferred provider.** If you must go to an independent lab or x-ray facility to receive preventive services, please make sure that the facility you visit is a preferred provider. Routine and preventive services received from a nonpreferred provider are subject to nonpreferred provider benefit provisions.

The following preventive services, including for the diagnosis of osteoporosis, are covered:

- routine physical, breast, and pelvic examinations
- routine immunizations in accordance with the state of New Mexico and the U.S. Preventive Services Task Force
- an annual routine gynecological examination and low-dose mammogram screenings, Pap tests, and papillomavirus screening in accordance with national medical standards
- periodic tests to determine blood hemoglobin, blood pressure, blood glucose level
- in accordance with recommendations of the U.S. Preventive Services Task Force:
  - periodic blood cholesterol, or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level
  - periodic stool examination for the presence of blood
  - periodic left-sided colon examination of 35 to 60 centimeters
  - periodic glaucoma eye tests
- routine pediatric immunizations in accordance with the American Academy of Pediatrics
- routine well-child physical examinations and associated testing, including school and sports physicals for children through age 17
- well-child care as recommended by the American Academy of Pediatrics
- routine vision screenings for children through age 17 to detect the *need* for visual and/or hearing correction when received as part of a routine physical exam by the child's physician (A screening does *not* include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)
- routine hearing screenings for children up to age 25 to detect the *need* for hearing correction when received as part of a routine physical exam by the child's physician (A screening does *not* include an exam or test to determine the amount and kind of correction needed.)

- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being (Diabetes self-management education programs are also covered when medically necessary. See "Physician Visits/Medical Care" for more information about diabetic services.

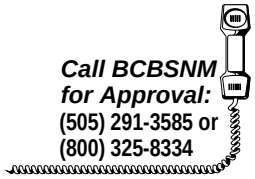
Exclusions — This Plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; or camp physicals
- immunizations or medications required for international travel
- routine eye examinations or any related service or supply; eye refractions; visual screening for members over age 17 (For benefits for hearing aids and associated testing, see "Supplies, Equipment, and Prosthetics.")

See Section 5: General Limitations and Exclusions

Short-Term Rehabilitation (Inpatient and Outpatient Physical, Occupational, Speech Therapy)

Short-term rehabilitation — A term used to describe inpatient and outpatient occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. Short-term rehabilitation does not include substance abuse rehabilitation.



Prior Approval Required — To be covered, all inpatient, outpatient, office, and home-based short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **prior approval** from BCBSNM. Short-term rehabilitation required due to reinjury or aggravation of an injury is also covered but must receive a separate **prior approval** from BCBSNM, even if therapy was authorized for the original injury.

Covered Services — This Plan covers the following short-term rehabilitation services when prescribed and/or provided for the medically necessary treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine or chiropractor)
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services (See "Hospital/Other Facility Services" for additional details.)

Conditions of Coverage — To be eligible for benefits, therapies must meet the following conditions:

- Services must be **prior-approved** by BCBSNM.
- There is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy.
- Improvement would not normally be expected to occur without intervention.

Exclusions — This Plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (See the "Long Term or Maintenance Therapy" exclusion in *Section 5.)*
- long-term therapy or therapy for the treatment of chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief (Therapies are long-term if measurable improvement is not possible within two months of beginning active therapy. See the "Long-Term or Maintenance Therapy" exclusion in *Section 5*.)
- diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- private room expenses

See Section 5: General Limitations and Exclusions

Smoking/Tobacco Use Cessation

For information about obtaining medications for smoking cessation treatment, refer to Express Scripts.

This Plan covers smoking cessation expenses. The benefit includes services covered under the medical portion of the Plan combined with smoking deterrents covered under the prescription drug portion of the Plan.

This benefit includes acupuncture, hypnotherapy, and other recognized smoking cessation programs, and related laboratory, x-ray, and other diagnostic tests, that are received through the medical portion of the Plan. (Contact Express Scripts for other covered services such as Nicorette or any other drug containing nicotine or other smoking deterrent medications.)

In order to utilize this benefit, members must secure medical services and pay for the services in full. **Note:** Prescription and nonprescription drug claims must be purchased through the prescription drug plan using your Express Scripts prescription drug plan ID card.

See Section 5: General Limitations and Exclusions

Supplies, Equipment, and Prosthetics

For contraceptive devices, see "Family Planning and Infertility."
For diabetic supplies such as needles, syringes, and test strips, call Express Scripts.
*For supplies or equipment used during an inpatient or outpatient stay, see "Hospital/Other Facility Services." (Supplies or equipment that are dispensed by a facility for use outside of the facility **are** subject to the provisions of this "Supplies, Equipment, and Prosthetics" section.)*

To be covered, items must be medically necessary and ordered by a health care provider. If you have a question about items not listed in this section, please call the BCBSNM Health Services department. **Prior approval** from BCBSNM is required for:

- items requiring rental
- orthopedic appliances and orthotics, regardless of total cost
- any item costing $500 or more in total charges *(Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use. Rental charges considered for benefit payment will not exceed the purchase price of a new unit.)

Diabetic Equipment — Under this provision of the Plan, the following supplies and equipment are covered for diabetic members and individuals with elevated blood glucose levels due to pregnancy:

- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps and insulin pump supplies (not to exceed a **30-day supply** purchased during any 30-day period)

- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics that have been **prior-approved** by BCBSNM, custom molded inserts, replacement inserts, preventive devices, and shoe modifications
- blood glucose monitors, including those for the legally blind

Reminder: Prior approval is required for items costing $500 or more or requiring rental. For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), call Express Scripts. **Note:** The Plan will also cover items not specifically listed as covered when new and improved equipment and appliances for the treatment and management of diabetes are approved by the United States Food and Drug Administration. This Plan will 1) maintain an adequate formulary to provide these resources to individuals with diabetes; and 2) guarantee reimbursement or coverage for the equipment, appliances, prescription drugs, insulin or supplies described in this booklet and/or your drug plan rider, issued by Express Scripts, within the limits of this Plan.

Durable Medical Equipment and Appliances — The following items are covered **(prior approval is required for items costing over $500 or requiring rental):**

- orthopedic appliances that have received **prior approval** from BCBSNM
- replacement of equipment or appliances only when required because of wear or damage (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement glasses/lenses are covered only if

a physician or optometrist recommends a change in prescription due to the patient's medical condition.)
- the rental (or at the option of BCBSNM, the purchase) of durable medical equipment (including repairs to purchased items), when prescribed by a covered health care provider and required for therapeutic use
- hearing aids, including hearing aid evaluation, repair, and replacement, and associated testing
- stethoscopes and blood pressure monitors that are prescribed by a physician

Note: Benefits for durable medical equipment, appliances, orthotics, and prosthetics received from a **nonpreferred** provider are limited each year to the amount indicated on the *Summary of Benefits*. (The limitation does not apply to hearing aids, oxygen, or oxygen equipment.) Benefits for durable medical equipment received from a preferred provider are not limited.

Medical Supplies — The following medical supplies are covered, not to exceed a **34-day supply** purchased during any 34-day period:
- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings
- mastectomy brassieres when required due to a mastectomy (Benefits are limited to **four** bras per Plan year.)
- support hose when prescribed by a physician (Benefits are limited to **six** pair of hose per Plan year.)
- other supplies determined by BCBSNM to be medically necessary and covered under the Plan (If you disagree with BCBSNM's decision regarding the medical necessity of any item, you may file a complaint. You may also request an external review of the BCBSNM decision at any time. See "Grievance Procedures" in *Section 7*.)

Orthotics, Prosthetics, and Implantable Devices — This Plan covers:
- *functional* orthotics, when **prior-approved,** and only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg
- surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury
- implantable mechanical devices such as cardiac defibrillators, insulin pumps, epidural pain pumps, and neurostimulators
- intraocular lenses; artificial eyes
- cochlear implants (See "Surgery and Related Services" for additional information about benefits available for cochlear implantation.)
- Teflon/Dacron surgical grafts and meshes
- artificial joints
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs, and replacement
- replacement of prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy

When alternative prosthetic/orthotic devices are available, the allowance for a prosthesis/orthotic will be based upon the least costly item.

Note: Benefits for durable medical equipment, appliances, orthotics, and prosthetics received from a nonpreferred provider are limited each year to the amount indicated on the *Summary of Benefits*. (The limitation does not apply to breast prosthetics.) Benefits for prosthetics and orthotics received from a preferred provider are not limited.

Exclusions — This Plan does **not** cover, regardless of the perceived value to promote or improve the overall health and well-being of the patient, items such as, but not limited to:

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- equipment that is primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chair-lifts, or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, hospital beds or mattresses, flotation mattresses, bathtub lifts, waterbeds, overbed tables, adjustable beds, or telephone arms
- repair costs that exceed the rental price of another unit for the estimated period of need or that exceed the purchase price of a new unit
- dental appliances (See "Dental-Related/TMJ Services" for exceptions.)
- syringes and needles for self-administering drugs other than insulin
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members may be eligible to receive benefits for these items. Call BCBSNM Health Services for details.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items or repairs to duplicate items; the replacement of items if required due to loss, theft, or destruction
- voice synthesizers or other communication devices
- eyeglasses or contact lenses and the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- items that can be purchased over-the-counter, including but not limited to contact lens solutions, dressings for bed sores or burns, gauze, or bandages
- items not listed as covered
- costs for items received from a nonpreferred provider that exceed the maximum benefit listed on the *Summary of Benefits*

See Section 5: General Limitations and Exclusions

Surgery and Related Services

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also include usual and related local anesthesia,

necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

Outpatient surgery — Any surgical service that is performed in an ambulatory surgical facility or the outpatient department of a hospital, but **not** including a procedure performed in an office or clinic. Outpatient surgery includes any procedure that requires the use of an ambulatory surgical facility or an outpatient hospital operating or recovery room.

For accidental injuries to the jaws, mouth, or teeth, or TMJ disorders or injuries, see "Dental-Related/TMJ Services."
For surgical sterilization and limited infertility-related treatments, see "Family Planning and Infertility."
If applicable, also see these topics:
"Hospital/Other Facility Services"
"Maternity Services"
"Transplant Services"

If a nonpreferred provider recommends surgery, you are responsible for obtaining admission review and/or other prior approval when necessary (see *Section 2*).

Surgeon's Services

Covered surgical services include surgeon's charges for a covered surgical procedure.

Cochlear Implants — This Plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device, is covered. (For hearing aids and associated testing, see "Supplies, Equipment, and Prosthetics.")

Mastectomy Services — This Plan covers medically necessary hospitalization related to a covered mastectomy (including at least 48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection).

This Plan also covers cosmetic breast surgery, when **prior-approved** by BCBSNM and received **within 12 months** of a mastectomy for breast cancer (unless a later procedure is approved as medically appropriate by BCBSNM).
Covered services are limited to:

- cosmetic surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures; and
- the initial surgery of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema.

This Plan does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery that has not received prior approval from BCBSNM.

Oral Surgery — Covered services include surgeon's charges for the following oral surgical procedures only:

- medically necessary orthognathic surgery
- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands, or ducts

- lingual frenectomy
- removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required

This Plan does **not** cover oral or dental procedures not specifically listed as covered such as, but not limited to:

- removal of tori, exostoses, or impacted teeth
- dental services required as the result of a medical condition or any medical or surgical procedure (e.g., chemotherapy or radiation therapy)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures

Reconstructive Surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect. Reconstructive surgery is covered when required to correct a **functional** disorder caused by:

- an accidental injury
- a disease process or its treatment (For breast surgery following a mastectomy, see "Mastectomy Services," on the previous page.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate)

You or your physician must obtain **prior approval, requested in writing,** from BCBSNM **before** the reconstructive service is provided. If the procedure (including any reconstructive service listed under "Oral Surgery") has not received prior approval, **the surgery and all related charges will be denied.** Cosmetic procedures and procedures that are not medically necessary, including all services related to such procedures, will also be **denied.**

Weight-Loss Surgery — The surgical treatment of morbid obesity is covered only if **prior approval, requested in writing,** has been obtained from BCBSNM before surgical treatment begins. Benefits are **not** available without this prior approval. (*Morbid obesity* means the state of being either 45 kilograms or 100 percent over ideal body weight.)

Exclusions — This Plan does **not** cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services," earlier in this section.)
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars or skin tags
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- sex change operations or complications arising from transsexual surgery
- services related to transplants not specifically listed as covered under "Transplant Services," later in this *Section 4*
- trimming of corns, calluses, or toenails (unless medically necessary as a result of diabetes), or trimming of bunions (except surgical treatment such as capsular or bone surgery)
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous

noncovered procedure (such as a noncovered organ transplant, sex change operation, or previous cosmetic surgery)
- any reconstructive procedure, weight-loss surgery, or cosmetic breast surgery that has not received prior approval from BCBSNM (Also see list of other surgical procedures requiring prior approval in *Section 2.)*
- the insertion of artificial organs or devices (Exception: The implantation of cardiac pacemakers, implantable cardiac defibrillators, implantable insulin pumps, implantable epidural pain pumps, neurostimulators, intraocular lenses, Teflon/Dacron surgical grafts and meshes, and cochlear implants and penile prosthetics.)
- standby services unless the procedure is identified by BCBSNM as requiring the services of a standby physician

Anesthesia Services

Covered services include necessary anesthesia services administered by a physician or certified registered nurse anesthetist (CRNA) during a covered surgical procedure. Anesthesia includes acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law. (See "Alternative Therapy: Acupuncture" for more information.)

Exclusions — This Plan does **not** cover local anesthesia. (Coverage for surgical procedures includes an allowance for local anesthesia because it is considered a routine part of the surgical procedure.)

Assistant Surgeon Services

Covered services include services of a professional provider who actively assists the operating surgeon in the performance of a covered surgical procedure when the procedure requires an assistant.

Exclusions — This Plan does **not** cover: services of an assistant only because the hospital or other facility requires such services; services performed by a resident, intern, or other salaried employee or person paid by the hospital; or services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon.

See Section 5: General Limitations and Exclusions

Transplant Services

Transplant — A surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and reimplanting the removed organ or tissue into the same person. Covered transplants include pre-screening for solid human organ transplants, islet cell infusion and autologous or allogeneic bone marrow transplants, including peripheral stem cell, as determined to be medically necessary.

Transplant-related services — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant, and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant.

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

Also see other subheadings in this section, such as "Hospital/Other Facility Services."

Prior Approval Required — **Prior approval, requested in writing,** must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if prior approval is not obtained from BCBSNM. A BCBSNM case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation.

If you are approved as a transplant recipient candidate, you must ensure that **prior approval** for the actual transplant is also received. None of the benefits described here are available unless you have this prior approval.

Facility Must Be in Transplant Network — Benefits for covered services will be approved only when the transplant is performed at a facility that, that for the transplant being provided, contracts directly with BCBSNM or through the BCBSNM national transplant network. Your BCBSNM case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call the BCBSNM Health Services department for information on the BCBSNM transplant programs.

Effect of Medicare Eligibility on Coverage — If you are now eligible for — or are *anticipating* receiving eligibility for — Medicare benefits, you should contact Medicare to ensure that the transplant will be eligible for Medicare benefits in order to maximize your coverage. See *Section 6* for details on coordination of benefits.

Organ Procurement or Donor Expenses — If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires surgery to make an organ available for a covered transplant (e.g., kidney or liver), coverage is available for expenses incurred by the donor for travel to and from the transplant facility (if required and approved by the case manager), surgery, organ storage expenses, and inpatient follow-up care only. These expenses *are* applied toward the $10,000 maximum lifetime benefit for donor expenses and to the maximum lifetime benefit for transplants described on the next page.

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

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

Cost-Sharing Provisions — Covered services related to transplants are subject to usual cost-sharing features and benefit limitations of this Plan (e.g., copayments; deductible, coinsurance, and out-of-pocket limits; annual home health care maximums).

In addition to the general provisions of the "Transplant Services" section, the following benefits, limitations, and exclusions apply to this coverage:

Travel, Food, and Lodging Expenses — If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate more than 60 miles outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. Also, a standard per diem benefit **($125)** will be allocated for food and lodging expenses for one additional adult traveling with the recipient. The recipient is eligible for per diem allowances for pre- and post-operative transplant care received on an outpatient basis. (If the transplant recipient is a dependent child under the age of 18, benefits for travel and per diem expenses for **two** adults to accompany the child are available.)

Travel expenses (supported by appropriate receipts or bills) for the recipient and the accompanying adult(s) and standard per diem allowances are limited to a lifetime maximum benefit of **$10,000** per transplant. Your case manager may approve travel and per diem allowances based upon the total number of days of temporary relocation, up to the maximum $10,000 benefit. These expenses and allowances are applied toward the maximum lifetime benefit for transplants (described below).

Travel expenses are **not** covered and per diem allowances are **not** paid:

- if you *choose* to travel to receive a transplant for which travel is not considered medically necessary by the case manager
- if the travel occurs more than five days before or more than one year following the actual transplant

Lifetime Maximum Benefit — Benefits for organ transplants and related services and supplies provided after the transplant (excluding drugs for use while at home) are limited to the amount specified on the *Summary of Benefits*. Benefits applied toward this maximum include payments for hospitalization and all covered charges for one or more transplants and subsequent hospitalizations and medical services related to a transplant. Donor expenses are included in the maximum benefit.

Exclusions — This Plan does **not** cover:

- any transplant-related expense in excess of the maximum lifetime benefit for transplants
- any transplant or organ-combination transplant not deemed to be medically necessary
- implantation of artificial organs or devices (mechanical heart); nonhuman organ transplants (See “Surgery and Related Services” for benefits related to implantation of mechanical devices such as insulin pumps, cochlear implants, and neurostimulators.)
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant that did not receive prior approval from BCBSNM
- services related to a transplant performed in a facility not contracted directly with BCBSNM or through the BCBSNM national transplant network
- expenses incurred by a member of this Plan to donate an organ to another person (These expenses should be paid by the plan of the person who is receiving the donated organ.)
- drugs that are self-administered or for use while at home (These services may be covered under your prescription drug plan.)
- lodging, food, beverage, or meal expenses that are not covered by the per diem allowance, if available

- travel or per diem expenses incurred more than five days before or more than one year following the date of transplantation; or if the recipient's case manager indicates that travel is not medically necessary
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as lodging received from a member of your family, or from any other person charging for accommodations in a place that does not ordinarily take in lodgers in return for payment)

See Section 5: General Limitations and Exclusions

5 General Limitations and Exclusions

Please read this section carefully. It identifies the limitations that apply to certain covered services and specifies the health care services and supplies that are not covered under this Plan. This Plan does not cover services that are not medically necessary as defined at the beginning of *Section 4* unless such services are specifically listed as covered. *General Limitations and Exclusions* do not apply to services covered under the FIT program that are provided to eligible children when not in excess of the maximum annual DOH reimbursement for such services.

Benefit limitations are described in the Summary of Benefits.

Any service, supply, item, or treatment not listed as a covered service in *Section 4* is not covered under this Plan. Benefits are not available for any of the following services, supplies, items, situations, or related expenses:

Admissions/Treatments Discontinued by Patient — **This Plan may not cover** charges associated with any episode of alcoholism or drug abuse for which the patient did not complete the prescribed continuum of care.

Before Effective Date or After Termination Date of Coverage — **This Plan does not cover** any service received, item purchased, or health care expense incurred before your effective date or after your termination date of coverage, even if: 1) prior approval for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered. If you are an inpatient when coverage begins, benefits for the admission will be available only for those covered services received on and after your effective date of coverage. Also see "Benefit Limits" in *Section 2*.

Benefits may be available for covered services received after your termination date during a hospital admission that began *before* coverage ended. Coverage for the admission and related inpatient services may continue until the earlier of the date: 1) benefits for the admission are exhausted, or 2) when there is an interruption of the inpatient stay (such as discharge or a leave of absence from the facility, regardless of the date of discharge). Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Plan.

Biofeedback — **This Plan does not cover** services related to biofeedback unless related to Reynaud's disease, urinary incontinence, chronic pain, tension headaches, migraines, and TMJ or CMJ disorders. Treatment must be provided by either a physician or a Board Certified Biofeedback Therapist. See "Alternative Therapy: Biofeedback" in *Section 4* for details.

Blood Services — **This Plan does not cover** blood charges if the blood has been replaced and blood donor storage fees if there is not a scheduled procedure.

See additional exclusions related to specific types of covered services in *Section 4.*

Chronic Pain Treatment — Chronic pain treatment is limited to services provided or prescribed by a physician (i.e., M.D. or D.O. only). Benefits for the treatment of chronic pain are also limited according to the type of service received (e.g., chiropractic services, acupuncture), as specified on the *Summary of Benefits*.

Commission of Felonious Acts — **This Plan does not cover** treatment for injuries sustained in the course of committing a felony is not covered under this Plan.

Complications of Noncovered Services — **This Plan does not cover** any services, treatments, or procedures required as the result of complications of a noncovered service, treatment, or procedure (e.g., due to a noncovered sex change operation, cosmetic surgery, transplant, or experimental procedure).

Convalescent Care or Rest Cures — **This Plan does not cover** convalescent care or rest cures.

Cosmetic Services — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. **This Plan does not cover** cosmetic surgery, services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. **This Plan does not cover** services related to or required as a result of a cosmetic service, procedure, or surgery, or subsequent procedures to correct unsatisfactory cosmetic results attained during an initial surgery.

Examples of cosmetic procedures are: dermabrasion; revision of surgically induced scars; breast augmentation; rhinoplasty; surgical alteration of the eye; correction of prognathism or micrognathism; excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, legs, or buttock; services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body including, but not limited to, breast, face, lips, jaw, chin, nose, ears, or genitals; or any procedures that BCBSNM determines are not required to materially improve the physiological function of an organ or body part.

Exception: Cosmetic breast/nipple surgery required due to a mastectomy that occurred less than **12 months** before the planned cosmetic procedure may be covered. However, **prior approval, requested in writing,** must be obtained from BCBSNM for such services. Also, prior-approved reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect. See *Section 4* for details.

Custodial Care — **This Plan does not cover** custodial care, or care in a place that is primarily your residence when you do not require skilled nursing. **This Plan does not cover** services to assist in activities of daily living (such as sitter's or homemaker's services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

See additional exclusions related to specific types of covered services in *Section 4.*

Dental-Related/TMJ Services — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 5*, see "Dental-Related/TMJ Services" in *Section 4* for additional exclusions.

Dependent of a Dependent (Grandchild) Expenses — **This Plan does not cover** services received by noncovered dependents, such as grandchildren, unless the dependent is otherwise eligible for coverage under this Plan.

Domiciliary Care — **This Plan does not cover** domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because your own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Duplicate (Double) Coverage — **This Plan does not cover** amounts already paid by other valid coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. See *Section 6* for more information. Also, if your prior coverage has an extension of benefits provision, **this Plan will not cover** charges incurred after your effective date under this Plan that are covered under the prior plan's extension of benefits provision.

Duplicate Equipment — **This Plan does not cover** duplicate equipment.

Duplicate Testing — **This Plan does not cover** duplicative diagnostic testing or overreads of laboratory, pathology, or radiology tests.

Experimental, Investigational, or Unproven Services — **This Plan does not cover** any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice,* as defined on the next page, or those considered experimental, investigational, or unproven. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental or investigational, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

See additional exclusions related to specific types of covered services in *Section 4.*

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 medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. *Experimental* or *investigational* does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

The service must be medically necessary and not excluded by any other contract exclusion.

Standard medical practice means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or other facility provider in which they were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

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

Food or Lodging Expenses — **This Plan does not cover** food or lodging expenses, except for those that are eligible for a per diem allowance under the "Transplant Services" provision in *Section 4* and not excluded by any other provision in this *Section 5*.

Foot Care (Routine) — **This Plan does not cover routine foot care,** including all routine services such as supportive devices, accommodative orthotics, orthopedic shoes (unless joined to braces), the treatment of flat foot conditions, partial dislocations, bunions (except capsular or bone surgery), fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails (unless medical conditions such as diabetes exist).

Genetic Testing or Counseling — **This Plan does not cover** routine genetic counseling or testing such as amniocentesis or ultrasound to determine the sex of an unborn child.

Hair Loss Treatments **— This Plan does not cover** wigs, artificial hairpieces, hair transplants or implants, or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

Hearing Exams, Procedures, or Aids — **This Plan does not cover** audiometric (hearing) tests unless 1) required for the diagnosis and/or treatment of an

See additional exclusions related to specific types of covered services in *Section 4.*

accidental injury or an illness, 2) covered as a preventive *screening* service for children up to age 25, or 3) covered as part of the hearing aid and associated testing benefit. (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) For hearing aids and surgically implanted devices, see "Supplies, Equipment, and Prosthetics" and "Surgery and Related Services" in *Section 4.*

Home Health/I.V. Services and Hospice — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 5,* see "Home Health/I.V. Services" and "Hospice Care" in *Section 4* for additional exclusions.

Hypnotherapy — **This Plan does not cover** hypnosis or services related to hypnosis, whether for medical or anesthetic purposes, except as covered under the "Smoking/Tobacco Use Cessation" provision in *Section 4.*

Infertility Services/Artificial Conception — **This Plan does not cover** services related to, but not limited to, procedures such as: artificial conception or insemination, fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro ("test tube") fertilization, Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT), embryo transfer, drugs for induced ovulation, or other artificial methods of conception. **This Plan does not cover** the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

This Plan does not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization. **This Plan does not cover** reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see "Family Planning and Infertility" in *Section 4*.)

Late Claims Filing — **This Plan does not cover** services of a nonparticipating provider if the claim for such services is received by BCBSNM more than **12 months** after the date of service. (Providers that contract with BCBSNM will file claims for you and must submit them within a specified amount of time.) If a claim is returned for further information, resubmit it **within 45 days. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change. See "Filing Claims" in *Section 7* for details.

Learning Deficiencies/Behavioral Problems — **This Plan does not cover** special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance. (See *Section 7* for reimbursement of certain services provided to eligible children by the Department of Health.)

See additional exclusions related to specific types of covered services in *Section 4.*

Limited Services/Covered Charges — **This Plan does not cover** amounts in excess of covered charges or services that exceed any maximum benefit limits listed in this benefit booklet, or any amendments, riders, addenda, or endorsements.

Local Anesthesia — **This Plan does not cover** local anesthesia. (Coverage for surgical, maternity, diagnostic, and other procedures includes an allowance for local anesthesia because it is considered a routine part of the procedure.)

Long-Term or Maintenance Therapy — **This Plan does not cover** long-term therapy whether for physical or for mental conditions, even if medically necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies are considered long-term if measurable improvement is not possible within two months of beginning active therapy. 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, childhood autism, muscular dystrophy, Down's syndrome, and cerebral palsy.) **Exception:** This Plan covers chronic pain treatment as described under "Chronic Pain Treatment" in this *Section 5*.

This Plan does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your physician supporting his/her opinion. **Note:** Even if your rehabilitative potential has not yet been reached, **this Plan does not cover** services that exceed maximum benefit limits.

Medical Policy Determinations — Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy (see "Medical policy" in the *Glossary).*

Medically Unnecessary Services — **This Plan does not cover** services that are not medically necessary as defined in *Section 4* unless such services are specifically listed as covered (e.g., see "Preventive Services" in *Section 4*). BCBSNM, in consultation with the preferred provider, determines whether a service or supply is medically necessary and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply does *not* make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. (When services are rendered by a nonpreferred provider, BCBSNM will determine medical necessity based on the criteria listed under "Medically Necessary Services" in *Section 4.)*

Note: If you disagree with BCBSNM's decision regarding the medical necessity of any item or service, you may file a complaint. You may also request an external review of the BCBSNM decision at any time. See "Grievance Procedures" in *Section 7*.

Mental Health and Substance Abuse — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 5*, see "Mental Health and Substance Abuse" in *Section 4* for additional exclusions.

See additional exclusions related to specific types of covered services in *Section 4.*

Mobile or Temporary Testing Units — **This Plan does not cover** bills from mobile or temporary testing units, including services for pap smears, OB/GYN services, and adult general screening and physicals.

No Legal Payment Obligation — **This Plan does not cover** services for which you have no legal obligation to pay or that are free, including:

- charges made only because benefits are available under this Plan
- services for which you have received a professional or courtesy discount
- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member
- physician charges exceeding the amount specified by CMS when primary benefits are payable under Medicare

Note: This exclusion does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services, Medicaid, or certain services that are reimbursed to the Department of Health according to the "Early Developmental Delay and Disability" provision in *Section 7*.

Noncovered Providers of Service — **This Plan does not cover** services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - school infirmary
  - halfway house
  - private sanitarium
  - extended care facility or similar institution
  - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group

Nonmedical Expenses — **This Plan does not cover** nonmedical expenses (even if medically recommended and regardless of therapeutic value), including costs for services or items such as, but not limited to:

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see "Preventive Services" and "Physician Visits/Medical Care" in *Section 4* for details.)
- vocational or training services and supplies
- mailing, shipping, handling, or delivery
- missed appointments; "get-acquainted" visits without physical assessment or medical care; telephone consultations; provision of medical information to perform admission review or other prior approvals; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities

See additional exclusions related to specific types of covered services in *Section 4.*

- personal convenience items such as air conditioners, humidifiers, breast pumps, or exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses)
- physicals or screening exams and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, or for any nonpreventive purpose (other than a routine school or sports physical for children through age 17)
- hepatitis B immunizations when required due to possible exposure during the member's work
- the cost of any damages to a treatment facility that are caused by the member

Nutritional Supplements and Nonprescription Drugs — **This Plan does not cover** herbal or homeopathic preparations, prescription drugs that have over-the-counter equivalents, vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, or any nonprescription drugs. (Insulin, certain smoking deterrents, and certain nutritional products may be covered, but must be purchased through the prescription drug plan. Call Express Scripts for information about these benefits and how to obtain them.)

Obesity Treatment — **This Plan does not cover** dietary or medical treatment of obesity unless the member meets the criteria for morbid obesity. (*Morbid obesity* means the state of being either 45 kilograms or 100 percent over ideal body weight.) Surgical treatments may be covered if prior-approved by BCBSNM. See "Surgery and Related Services" in *Section 4* for details.

Pre-Existing Conditions — **This Plan does not cover** pre-existing conditions (as specified in *Section 3)* of late applicants in full for up to one year at the Nonpreferred Provider level of benefits under this Plan.

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, and Special Medical Foods — These items are not are not covered under the medical/surgical portion of this Plan. If you have questions about your outpatient prescription drug benefits, contact Express Scripts. (Express Scripts is not affiliated with BCBSNM.)

Prior Approval Not Obtained When Required — **This Plan does not cover** certain services if you do not obtain prior approval from BCBSNM before those services are received. See "Admission Review and Other Prior Approvals" in *Section 2*.

Private Duty Nursing Services — **This Plan does not cover** private duty nursing services.

Private Room Expenses — **This Plan does not cover** private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation

See additional exclusions related to specific types of covered services in *Section 4.*

according to public health laws). Private room charges must be **prior-approved** by BCBSNM to be covered.

Sex-Change Operations or Services — **This Plan does not cover** services related to sex-change operations, reversals of such procedures, or complications arising from transsexual surgery.

Sexual Dysfunction Treatment — **This Plan does not cover** services related to the treatment of sexual dysfunction.

Supplies, Equipment, and Prosthetics — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 5,* see "Supplies, Equipment, and Prosthetics" in *Section 4* for additional exclusions.

Surgery and Related Services — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 5,* see "Surgery and Related Services" in *Section 4* for additional exclusions.

Therapy and Counseling Services — **This Plan does not cover** therapies and counseling programs other than the therapies listed as covered in this booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this *Section 5,* **this Plan does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, codependency, and weight-loss programs
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, religious, or marital counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)

Also see topics in *Section 4* for exclusions related to therapy and counseling.

Thermography **— This Plan does not cover** thermography (a technique that photographically represents the surface temperatures of the body).

Transplant Services — Please see "Transplant Services" in *Section 4* for specific transplant services that are covered and related limitations and exclusions. In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 5,* **this Plan does not cover** any other transplants (or organ-combination transplants) or services related to any other transplants.

Travel or Transportation — This Plan does not cover travel, taxicab or bus fare, parking, vehicle rental, or similar expenses (even if travel is necessary to receive covered services), unless such services are eligible for coverage and not excluded under "Early Developmental Delay and Disability" in *Section 7,* or "Transplant Services," or "Ambulance Services" in *Section 4*.

See additional exclusions related to specific types of covered services in *Section 4.*

Veteran's Administration Facility — **This Plan does not cover** services or supplies furnished by a Veterans Administration facility for a service-connected disability or while a member is in active military service.

Vision Services — **This Plan does not cover** any services related to lasik surgery or refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty or lasik surgery, including radial keratotomy or any procedure designed to correct myopia, or any procedure to correct refractive defects such as farsightedness, presbyopia, or astigmatism, including eye refraction. **This Plan does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under "Supplies, Equipment, and Prosthetics" in *Section 4*. **This Plan does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

War-Related Conditions — **This Plan does not cover** any service required as the result of any act of war or related to an illness or accidental injury sustained during combat or active military service.

Weight Loss Programs — **This Plan does not cover** weight loss programs, obesity treatment, and related nutritional counseling, except **prior-approved** surgical treatment of morbid obesity that has been approved by BCBSNM before treatment begins. Nutritional counseling, received in conjunction with the surgical procedure and arranged by the surgeon, will be covered.

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

- occupational disease laws
- employer's liability
- municipal, state, or federal law (except Medicaid)
- Workers' Compensation Act

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (BCBSNM may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

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

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

Note: The "Work-Related Conditions" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and that you are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

See additional exclusions related to specific types of covered services in *Section 4.*

6 COB and Reimbursement

Coordination of Benefits (COB)

Other valid coverage — All other group and individual (or direct-pay) insurance policies or health care benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services.

For a work-related injury or condition, see the "Work-Related Conditions" exclusion in Section 5.

This Plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM's covered charges.

If you are also covered by Medicare, special COB rules may apply. Contact a Customer Service representative for more information. If you are enrolled in federal continuation coverage, coverage ends at the beginning of the month when you become entitled to Medicare or when you become insured under any other valid coverage (unless a pre-existing conditions limitation applies).

When this Plan is secondary, all provisions (such as obtaining prior approval) must be followed or benefits may be denied or reduced.

The following rules determine which coverage pays first:

No COB Provision — If the other valid coverage does not include a COB provision, that coverage pays first.

Medicare — If the other valid coverage is Medicare and Medicare is primary according to federal regulation, Medicare pays first. (See "Effect of Medicare on Benefits," on the next page.)

Subscriber/Dependent — If a member is covered as the subscriber under one coverage and as a dependent under another, the subscriber's coverage pays first. **Exception:** If Medicare is secondary to the plan of an *active* worker covering the Medicare beneficiary as a dependent, then that plan determines its benefits first, then Medicare, and last, the plan covering the Medicare beneficiary as the subscriber.

If you have other valid group coverage *and* Medicare, contact the other carrier's customer service department to find out if the other coverage is primary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may not be subject to those provisions.

Dependent Child — For a dependent child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other coverage does not follow this rule, the father's coverage pays first.

Dependent Child, Parents Separated or Divorced — For a dependent child of divorced or separated parents, benefits are coordinated in the following order:

- *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
- *Joint Custody.* If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

Active/Inactive Employee — If a member is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a member is covered as a dependent under both coverages, the coverage through active employment pays first.) If the other plan does not have this rule and the plans do not agree on the order of benefits, the next rule applies.

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

Effect of Medicare on Benefits

Shortly before you or your spouse become age 65, or if you or any other family member becomes qualified for Medicare benefits, contact your local Social Security office to establish Medicare eligibility. Then, contact the Benefits Department to discuss coverage options.

If you are a working employee age 65 or over or your spouse is age 65 or over, you are eligible to continue the State of New Mexico Plan coverage on the same basis as members under age 65.

If Medicare coverage coexists with this Plan, Medicare will be secondary until the Plan pays primary for either 30 months from the date the member became eligible for or entitled to Medicare on the basis of end-stage renal disease or until Medicare otherwise becomes primary as provided by federal law, whichever occurs sooner. A person eligible under Medicare is defined as an employee or dependent who is enrolled and covered under the voluntary portion (Part B) of Medicare, or who has been eligible to enroll under such part. All individuals who are eligible to enroll for Medicare Part B but have not done so, will be treated the same as all other persons eligible under Medicare and BCBSNM will assume that eligible members have Part B coverage. Plan benefits will be offset with Medicare Part B benefits whether or not the member actually receives them.

Responsibility for Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

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

Right of Recovery

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

Reimbursement Provision

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services described in this benefit booklet, you agree:

BCBSNM and the State of New Mexico have the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total covered charges for covered services for which the Plan provided benefits to you or your dependents.

BCBSNM and the State of New Mexico are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Plan provided for that sickness or injury.

The State of New Mexico shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Plan has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM may reasonably require in order to obtain the State of New Mexico's rights under this provision. This provision applies whether or not the third party admits liability.

7 Claims Payments and Appeals

Filing Claims

You must submit claims **within 12 months** after the date services or supplies were received. **A claim submitted more than 12 months after the service was received will not be accepted under any circumstance. Note:** If there is a change in the Claim Administrator, the length of this timely filing period may also change. If a claim is returned for further information, resubmit it **within 45 days.**

Important Note About Filing Claims and Appeals — **This section addresses the procedures for filing claims and appeals.** The instructions in no way imply that filing a claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this benefit booklet. All claims submitted will be processed by BCBSNM according to the patient's eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all admission review and prior approval requirements or benefits may be reduced or denied as explained in *Section 2*. Covered services are the same services listed as covered in *Section 4* and all services are subject to the limitations and exclusions listed throughout this booklet.

If You Have Other Coverage — When you have other coverage that is "primary" over this Plan, you need to file your claim with the other coverage first. (See *Section 6: COB and Reimbursement*.)

After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under "Where to Send Claim Forms," on the next page.

If the other coverage pays benefits to you (or your family member) directly, give your provider a copy of the payment explanation so that he/she can include it with the claim sent to BCBSNM or to the local BCBS Plan. (If a nonpreferred provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to BCBSNM or to the local BCBS Plan, as applicable.)

Participating and Preferred Providers

Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred contract and another "participating" provider contract. Some providers have only the participating provider contract and are not considered preferred. However, all participating and preferred providers, including PPPs, file claims with their local BCBS Plan and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

Preferred providers (and participating providers) also have specific timely filing limits in their contracts with BCBSNM. The contract language lets providers

know that they may not bill the employer or any member if they do not meet that filing limit for a service and the claim for that service is denied.

Nonparticipating Providers

A nonparticipating provider is one that has neither a preferred nor a participating provider agreement. If your nonparticipating provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other coverage's payment explanation, to a *Member Claim Form*. (Forms can be printed from the BCBSNM Web site or requested from a Customer Service representative.) Complete the claim form using the instructions on the form. (See special claims filing instructions for out-of-country claims under "Where to Send Claim Forms," below.)

Itemized Bills — Claims for covered services must be itemized on the provider's billing forms or letterhead stationery and must show:

- member's identification number
- member's and subscriber's name and address
- member's date of birth and relationship to the subscriber
- name and address of health care provider, including tax ID or social security number
- date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- accident or surgery date (when applicable)

Correctly itemized bills are necessary for your claim to be processed. The only acceptable bills are those from health care providers. Do **not** file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send them. The bills are not returned to you. All information on the claim and itemized bills must be readable. If information is missing or is not readable, BCBSNM will return it to you or the provider. Do not file for the same service twice unless asked to do so by a Customer Service representative. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting.

All itemized bills for services received outside the United States must be translated into English before being filed with BCBSNM. (See the next page for special instructions regarding out-of-country claims.)

Where to Send Claim Forms

If your provider does not file a claim for you, you (not the provider) are responsible for filing the claim. **Remember:** Network providers will file claims for you; the procedures below are only used when you must file your own claim.

Behavioral Health Services — Claims for out-of-network mental health, alcoholism rehabilitation, and drug abuse services received in New Mexico should be submitted to:

Mesa Mental Health
P.O. Box 92165
Albuquerque, NM 87199-2165

Drug Plan Claims — Claims for items covered under the drug plan (e.g., prescription drugs, smoking deterrents and enteral nutritional products, insulin, needles, and syringes) must be sent to Express Scripts — **not** to BCBSNM.

Medical/Surgical Services — When covered medical/surgical services are received from an out-of-network provider in New Mexico, mail the forms and itemized bills to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Services Outside New Mexico — Claims for covered services received outside New Mexico from providers that do not contract directly with BCBSNM (or Mesa Mental Health) should be mailed to the BCBS Plan in the state where services were received. If a provider will not file a claim for you, ask for an itemized bill, complete a member claim form, and mail both forms to the BCBS Plan of that state.

Canada and Puerto Rico — Claims for covered services received in Canada or Puerto Rico should be handled the same way as is described in "Services Outside New Mexico," above.

Outside the United States — For inpatient hospital services received outside the United States (including Puerto Rico) and Canada, show your BCBSNM ID card. BCBSNM participates in a claims payment program with the Blue Cross and Blue Shield Association.

If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then BCBSNM reimburses the other Plan.

For 1) *any* covered services at hospitals that do *not* contract with the Association, 2) *all* covered outpatient hospital services, and 3) *all* covered physician services, you must pay for the services or supplies if the provider is unable to negotiate payment arrangements before discharge. Make copies of your itemized bills and translate them into English. Submit the original itemized bills, along with the translation, to BCBSNM as described under "Nonparticipating Providers," on the previous page.

How Payments Are Made

After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not. **Note:** If a Qualified Child Medical Support Order (QCMSO) is in effect, the QCMSO provisions will be followed. For example, when the member is a dependent child of divorced parents, the custodial parent may receive the payment and the EOB.

Participating and Preferred Providers — Payments for covered services usually are sent directly to PPPs and other network providers. The EOB you receive explains the payment.

Nonparticipating Providers — If services are received from a nonparticipating provider in New Mexico and the member has not assigned benefits to the provider, payments are made to the subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any benefit reduction amounts, and noncovered expenses.

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

Assignment of Benefits — BCBSNM will honor assignments made to nonpreferred providers in New Mexico. No person may execute any power of attorney to interfere with BCBSNM's right to pay the subscriber or his/her representative instead of anyone else.

Early Developmental Delay and Disability — For covered dependent children under age 4 who are also eligible for services under the Department of Health's (DOH) "Family, Infant, and Toddler" (FIT) program (as defined in 7.30.8, NMAC), your health care plan will reimburse the DOH for certain medically necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH's FIT program. The maximum reimbursement under the Plan is limited to **$3,500** per year (not subject to deductible, coinsurance, copayment, or out-of-pocket limit provisions). Amounts paid to the DOH for such services are not included in any annual or lifetime benefit maximums under the Plan. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the DOH.

Covered Charge — Provider payments are based upon preferred provider agreements and covered charges as determined by BCBSNM. For services received outside of New Mexico, covered charges may be based on the local Plan practice. You are responsible for paying copayments, deductibles, coinsurance, any benefit reduction amounts, and noncovered expenses. For covered services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

BlueCard Program — BCBSNM hereby informs you that other Blue Cross and Blue Shield Plans outside of New Mexico ("Host Blue") may have contracts with certain providers in their service areas. Under BlueCard, when you receive covered health care services outside of New Mexico from a Host Blue contracting provider that does not have a contract with BCBSNM, the amount you pay for covered services is calculated on the lower of:

- the billed charges for your covered services, or
- the negotiated price that the Host Blue passes on to BCBSNM.

Often, this "negotiated price" is a **simple discount** that reflects the actual price the Host Blue pays. Sometimes, it is an **estimated price** that takes into account special arrangements the Host Blue has with an individual provider or a group of providers. Such arrangements may include settlements, withholds, non-claims transactions, and/or other types of variable payments. The "negotiated price" may also be an **average price** based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted from time to time to correct for over- or underestimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price. Laws in a small number of states may require the Host Blue to 1) use another method for, or 2) add a surcharge to, your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any covered services according to the applicable state law in effect when you received care.

Accident-Related Hospital Services — If services are administered as a result of an accident, a hospital or treatment facility may place a lien upon a compromise, settlement, or judgement obtained by you when the facility has not been paid its total billed charges from all other sources.

Overpayments — If BCBSNM makes an erroneous benefit payment for any reason (e.g., provider billing error, claims processing error), BCBSNM and the providers of care may recover overpayments from you. If you do not refund the overpayment, BCBSNM reserves the right to withhold future benefits to apply to the amount that you owe BCBSNM, and to take legal action to correct payments made in error.

Grievance Procedures

Many grievances or problems can be handled informally by calling the BCBSNM State of New Mexico Dedicated Service Unit at 1-877-994-2583. Any grievance may be submitted orally or in writing. If you make an oral grievance, BCBSNM's Dedicated Service Unit representative will help you complete the required forms. Please be advised that BCBSNM shall not take any retaliatory action against you for filing a complaint or grievance.

BCBSNM 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 BCBSNM to deny, reduce or terminate a requested health care service that requires prior approval on the grounds that it is either not a covered benefit or it is not medically necessary, see "Utilization Management Review Procedures," below.

If your grievance concerns any other action or inaction by BCBSNM concerning any other aspect of this health benefits plan, such as the denial or partial payment of a claim, see "Non-Utilization Management Review Procedures," on the next page.

You may request a copy and detailed written explanation of the grievance procedures by calling BCBSNM at 1-877-994-2583. **Note:** If you have a complaint regarding the quality of care, choice of providers, or adequacy of the network, all information you provide will be submitted to BCBSNM's Quality Management and Improvement department for review.

Utilization Management Review Procedures

When you or your treating health care professional requests a health care service, BCBSNM shall initially determine whether the requested health care service is covered by your health benefits plan and is medically necessary within 24 hours where circumstances require expedited review and 5 working days for all other cases. If BCBSNM's initial review results in the denial, reduction or termination of the requested health care service, then BCBSNM will notify you of the determination and of your right to request internal review by BCBSNM. You may request an internal review orally or in writing by contacting:

State of New Mexico Dedicated Service Unit, Grievance Coordinator
Mailing Address: P.O. Box 27630
Albuquerque, New Mexico 87125-7630
Telephone: toll-free at 1-877-944-2583
E-mail: sonmcorr@bcbsnm.com
Fax: (505) 889-2601

BCBSNM's internal utilization management review procedures require an initial review by a BCBSNM 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 the BCBSNM medical director decides to uphold the denial, reduction or termination of the requested health care service, then BCBSNM 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 health care insurer.

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

Non-Utilization Management Review Procedures

If you are dissatisfied with a decision, action or inaction of BCBSNM 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 BCBSNM internally review the matter. First, a BCBSNM 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 from BCBSNM. BCBSNM will appoint a reconsideration committee to review the grievance and will schedule a hearing. BCBSNM will notify you of the date, time and location of the hearing and of your rights in the process. BCBSNM will mail you a written decision within 7 working days after the hearing.

State of NM Grievance Review Procedures

If the grievant is not satisfied with BCBSNM's decision under either category above, he/she may appeal the decision by filing a formal complaint to the State of New Mexico's General Services Department, Risk Management Division (GSD/RMD) within 30 days of the day the grievance decision was made. **(Note:** You may contact GSD/RMD at any time during the grievance process.) Upon receipt of the appeal request, the State of New Mexico's GSD/RMD will review the case and respond to the parties involved within 30 days. If the appeal is due to an emergency situation, a response will be given within 48 hours of receipt of the formal appeal request.

General Services Department, Risk Management Division, Benefits/Insurance Bureau
1100 St. Francis, Room 2073
P.O. Drawer 26110
Santa Fe, New Mexico 87502
Toll-free phone number: 1-877-301-8041
Fax: 505-827-2843

External Review by Superintendent of Insurance

If you are dissatisfied with the results of the internal review by BCBSNM, the medical panel, or the State of New Mexico GSD/RMD, you may request an external review by the New Mexico Superintendent of Insurance by filing a written request within 20 working days from the date you receive the GSD/RMD or BCBSNM decision. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;
- Fax to the Superintendent of Insurance, Attention: Managed Health Care Bureau - External Review Request, at (505) 827-4734.

You will need to provide a copy of the BCBSNM or the State of New Mexico's GSD/RMD's internal review decision; a fully executed release form authorizing the Superintendent to obtain any necessary medical records from BCBSNM or other health care service provider; and any other supporting documentation. You may contact the Managed Health Care Bureau to assist you in this process.

Retaliatory Action

BCBSNM shall not take any retaliatory action against you for filing a grievance under this health benefits plan.

Binding Arbitration

If a dispute about coverage, benefits, or handling of claims or appeals continues after you have followed and exhausted the reconsideration and external appeal process set forth above, the issue or claim may be submitted to binding arbitration. The rules for arbitration shall be the "Commercial Arbitration Rules" developed by the American Arbitration Association (AAA) and any other applicable AAA rules or procedures. You may obtain a copy of these rules from an SONM Customer Service representative. The rules are also available from the American Arbitration Association's Web site (www.adr.org).

The decisions in arbitration are binding upon both you and the Plan. Judgment on the award given in arbitration may be enforced in any court that has proper authority. Damages, if any, are limited to the amount of the benefit payment in dispute plus reasonable costs. The State of New Mexico and BCBSNM, including Health Care Services Corporation (HCSC), are not liable for punitive damages or attorney fees. This is a mandatory arbitration clause, meaning that if you choose to continue with your dispute against the Claims Administrator or the State of New Mexico, it must be through an AAA arbitration. You are barred from filing a legal action (civil lawsuit) against the SONM or BCBSNM (including HCSC).

No arbitration demand may be made less than 60 days after BCBSNM has received the claim for benefits or prior approval request, or later than three years after the date that the claim for benefits should have been filed with BCBSNM.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond BCBSNM's control, BCBSNM may be unable to process claims or provide prior approval for services on a timely basis. If due to circumstances not within the control of BCBSNM or a preferred provider (such as partial or complete destruction of facilities, war, riot, disability of a preferred provider, or similar case), BCBSNM and the provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and preferred providers will, however, make a good-faith effort to provide services.

Research Fees

BCBSNM reserves the right to charge you a reasonable administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms.

Sending Notices

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to the subscriber at the latest address on BCBSNM membership records or to the employer.

8 General Provisions

Availability of Provider Services

BCBSNM does not guarantee that a certain type of room or service will be available at any hospital or other facility within the BCBSNM network, nor that the services of a particular hospital, physician, or other provider will be available.

Changes to the Benefit Booklet

No employee of BCBSNM may change this benefit booklet by giving incomplete or incorrect information, or by contradicting the terms of this benefit booklet. Any such situation will not prevent BCBSNM from administering this benefit booklet in strict accordance with its terms.

Consumer Advisory Board

BCBSNM has established a Consumer Advisory Board to provide input from the member's point-of-view about BCBSNM's general operations and internal policies and to identify areas that need improvement.

Disclaimer of Liability

BCBSNM has no control over any diagnosis, treatment, care, or other service provided to you by any facility or professional provider, whether preferred or not. BCBSNM is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

Disclosure and Release of Information

BCBSNM will only disclose information as permitted or required under state and federal law.

Execution of Papers

On behalf of yourself and your dependents you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this Plan.

Independent Contractors

The relationship between BCBSNM and its preferred providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any preferred provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any preferred provider.

The relationship between BCBSNM and the group is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of the employer.

Member Rights

As a member enrolled in a health care plan administered by BCBSNM, you have these rights:

- The right to available and accessible services when medically necessary as determined by your primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined by your benefit booklet.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, appeals procedures and other information about the company and the benefits provided.
- The right to choose a provider within the limits of the covered benefits and Plan network, including the right to refuse care of specific practitioners.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if available, and documented in your medical record.
- The right to prompt notification of termination or changes in benefits, services or provider network.
- The right to file a complaint or appeal with BCBSNM or with the New Mexico Superintendent of Insurance and to receive an answer to those complaints within a reasonable time.
- The right to privacy of medical and financial records maintained by BCBSNM and health care providers contracted with BCBSNM, in accordance with existing law.
- The right to request information about any financial arrangements or provisions between BCBSNM and its contracting providers that may restrict referral or treatment options or limit the services offered to members.
- The right to adequate access to qualified health professionals near your work or home within the service area of BCBSNM.
- The right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a nonpreferred provider, and an explanation of your financial responsibility when services are provided by a nonpreferred provider, or provided without required prior approval.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for prior approval and utilization review.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review, the right to a secondary appeal, and the right to request the assistance of the Superintendent of Insurance.

Member Responsibilities

As a member enrolled in a health care plan administered by BCBSNM, you have these responsibilities:

- The responsibility to supply information (to the extent possible) that BCBSNM and its preferred practitioners and providers need in order to provide care.
- The responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners.
- The responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals with your treating provider or practitioner to the degree possible.

9 Glossary

It is important for you to understand the meaning of the following terms. The definition of many terms determines your benefit eligibility.

Accidental injury — 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 — The use of needles inserted into the human 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 health.

Admission — The period of time between the dates a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date. Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Plan.) Also see the exclusion for services received "Before Effective Date or After Termination Date of Coverage" in *Section 5* and "Benefit Limits" in *Section 2*.

Alcoholism — A condition defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol. There may also be significant risk of severe withdrawal symptoms if the use of alcohol is discontinued.

Alcoholism treatment facility, alcoholism treatment program — An appropriately licensed provider of detoxification and rehabilitation treatment for alcoholism.

Ambulance — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ambulatory surgical facility — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

Appliance — A device used to provide a functional or therapeutic effect.

Benefit booklet — This document, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Biofeedback — Training and other necessary services (such as the use of special equipment) related to making certain bodily processes (e.g., heartbeats or brain waves) perceptible to the senses so they can be mentally controlled.

Blue Cross and Blue Shield of New Mexico (BCBSNM) — The Claim Administrator of this PPO Health Plan, as selected by the State of New Mexico. BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Cardiac rehabilitation — An individualized, supervised physical reconditioning exercise session usually lasting from 4 to 12 weeks. Also includes education on nutrition and heart disease.

Certified nurse-midwife — A person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a certified nurse-midwife.

Certified nurse practitioner — A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the Board of Nursing.

Chemical dependency — See "Substance abuse."

Chemotherapy — Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractic services — Any service or supply administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico or the state in which services are rendered.

Chiropractor — A person who is a doctor of chiropractic (D.C.) licensed by the appropriate governmental agency to practice chiropractic medicine.

Church plan — That term as defined pursuant to Section 3(33) of the federal Employee Retirement Income Security Act of 1974.

Claims Administrator — As selected by the State of New Mexico, the Claims Administrator for the medical/surgical portion of this Plan is BCBSNM, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Clinical psychologist — A person with a doctoral degree in clinical psychology licensed or certified in accordance with the New Mexico Professional Psychologist Act or similar statute in another state.

Coinsurance — The percentage of a covered charge that is your responsibility to pay. For covered services that are subject to coinsurance, you pay the percentage (indicated on the *Summary of Benefits*) of BCBSNM's covered charge after the deductible has been met.

Copayment — The fixed-dollar amount of a covered charge that you pay for some services (e.g., hospital admissions to a preferred facility, urgent care, emergency room, PPP office visits).

Cosmetic — See the "Cosmetic Services" exclusion in *Section 5*.

Cost effective — A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.

Covered charge — See "How Payments Are Made" in *Section 7*.

Covered services — Services or supplies that are listed in this benefit booklet, including any endorsements, addenda, or riders, for which benefits are provided.

Creditable coverage — Health care coverage through an employment-based group health plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe, or pueblo; the NM Medical Insurance Pool (NMMIP) Act or similar state-sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Deductible — The amount of money that you must pay in a Plan year before this Plan pays benefits for all or part of your remaining covered charges incurred during the rest of the Plan year. There is a separate deductible for Preferred Provider services vs. Nonpreferred Provider services. Your deductibles are indicated on the *Summary of Benefits*.

Dental-related services — Services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Dentist, oral surgeon — A doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, accidental injuries, and malformation of the teeth, jaws, and mouth.

Dependent — A person entitled to apply for coverage as specified in *Section 3: Enrollment and Termination*.

Diagnostic services — Procedures such as laboratory and pathology tests, x-ray services, EKGs, and EEGs that do not require the use of an operating or recovery room, and that are ordered by a provider to determine a condition or disease.

Dialysis — The treatment of a kidney ailment during which impurities are mechanically removed from the body with dialysis equipment.

Doctor of oriental medicine — A person who is a doctor of oriental medicine (D.O.M.) licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

Drug abuse — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs or other substance is discontinued. Drug abuse does not include nicotine addiction or alcohol use.

Drug plan — The portion of the State of New Mexico health care plan that is administered by Express Scripts and provides benefits and coverage for prescription drugs, insulin, diabetic supplies, nonprescription enteral nutritional products, and special medical foods required for inborn errors of metabolism.

Durable medical equipment — Any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured.

Effective date of coverage — 12:01 A.M. of the date on which a member's coverage begins.

Emergency care — Medical or surgical procedures, treatments, or services delivered immediately after an accidental injury or the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement. Initial treatment must be sought within 48 hours of the accident or onset of symptoms to qualify as an emergency. If you are hospitalized within 48 hours of an emergency occurrence, the related inpatient hospitalization is considered part of the initial treatment.

Employee probationary period — The number of months or days of continuous employment beginning with the employee's most recent date of hire and ending on the date the employee first becomes eligible for coverage under the employer's group.

Experimental, investigational, or unproven — See the "Experimental, Investigational, or Unproven Services" exclusion in *Section 5*.

Facility — A hospital (see "Hospital," on the next page) or other institution (see "Provider," later in this section).

Genetic inborn error of metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

Good cause — Failure of the subscriber to pay the premiums or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this Plan; or fraud or material misrepresentation affecting coverage.

Governmental plan — That term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental plan (a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government).

Grievance — An oral or written complaint submitted by or on behalf of a covered person regarding the:

- availability, delivery, or quality of health care services
- administrative practices of the health care insurer that affect the availability, delivery, or quality of health care services
- claims payment, handling, or reimbursement for health care services
- matters pertaining to any aspect of the health benefits plan

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

Group health plan — An employee welfare benefit plan as defined in Section 3 (1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement, or otherwise) to employees or their dependents (as defined under the terms of the plan).

Health care professional — A physician or other health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provided health care services consistent with state law.

Health care services — Services, supplies, and procedures for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits Plan, physical and mental health, including community-based mental health.

Home health care agency — An appropriately licensed provider that both:

- brings skilled nursing and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for home health care agencies in New Mexico or in the state where the services are provided; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending physician.

Hospice — A licensed program providing care and support to terminally ill patients and their families. An approved hospice must be licensed when required, Medicare-certified as, or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as, a hospice.

Hospice benefit period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends six months after the period began (or upon the member's death, if sooner). The hospice benefit period must begin while the member is covered for these benefits, and coverage must be maintained throughout the hospice benefit period.

Hospice care — An alternative way of caring for terminally ill individuals in the home or institutional setting, which stresses controlling pain and relieving symptoms but does not cure. Supportive services are offered to the family before and after the death of the patient.

Hospital — A health institution offering facilities, beds, and continuous services 24 hours a day, 7 days a week. The hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:

- diagnosis and treatment of illness, injury, deformity, abnormality, or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution

- treatment facilities for emergency and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well-defined plan and related to community needs.)

A hospital is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis; ordinarily does not provide hospice or rehabilitation care; and is not a residential treatment facility.

Identification card (ID card) — The card BCBSNM issues to the subscriber that identifies the cardholder as a Plan member. (You should receive a separate ID card from Express Scripts to use for purchasing items covered under the prescription drug plan portion of the Plan.)

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 3–12 hours of continuous psychiatric care in a treatment facility).

Involuntary loss of coverage — For purposes of the "Special Enrollment" provision in *Section 3,* "involuntary loss of coverage" means loss of other coverage due to the following reasons only: legal separation, divorce, death, moving out of an HMO service area, termination of employment, reduction in hours, or termination of employer contributions (even if the affected member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option, and no substitute plan was offered. If the member is covered under a state or federal continuation policy due to prior employment, involuntary loss of coverage includes exhaustion of the maximum continuation time period. Involuntary loss of coverage does not include a loss of coverage due to the failure of the individual or member to pay premiums on a timely basis or termination of coverage for cause.

Licensed midwife — A person who practices lay midwifery and is registered as a licensed midwife by the New Mexico Department of Health or by the appropriate regulatory body in the state where services are received.

Licensed practical nurse (L.P.N.) — A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

Massage therapy services — Manipulation of tissues with the hand or an instrument for therapeutic purposes.

Maternity — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care, and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion, or cesarean section. See "Maternity Services" in *Section 4* for more information.

Medicaid — A state-funded program that provides medical care for indigent persons, as established under Title XIV of the Social Security Act of 1965, as amended.

Medical detoxification — Treatment for withdrawal from the physiological effects of alcoholism or drug abuse.

Medical policy — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate claims and provide benefits for covered services. Medical policies are posted on the BCBSNM Web site for review or copies of specific medical policies may be requested in writing from a customer service representative.

Medical supplies — Expendable items (except prescription drugs), ordered by a physician or other professional provider, that are required for the treatment of an illness or injury.

Medically necessary, medical necessity — See "Medically Necessary Services" at the beginning of *Section 4*.

Medicare — The program of health care for the aged, end-stage renal disease (ESRD) patients, and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member — The enrollee (the subscriber or any eligible dependent) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Professional Services Agreement. Throughout this booklet, the terms "you" and "your" refer to each member.

Mental disorder, mental illness — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental illness does not include developmental disabilities, drug or alcohol abuse, or learning disabilities.

Nonparticipating provider — An appropriately licensed health care provider that has not contracted directly or indirectly, for the service being provided, with BCBSNM.

Nonpreferred provider — Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "preferred" or "PPO" provider network. (These providers may have "participating" provider agreements, but are **not** considered "preferred." See "Participating provider," on the next page, for more information.) **Note:** See your *Summary of Benefits* for those services that are not covered if received from a nonpreferred provider.

Occupational therapist — A person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction caused by disease, trauma, congenital anomaly, or prior therapeutic process through the use of specific tasks or goal-directed activities designed to improve functional performance of the patient.

Occupational therapy — The use of rehabilitative techniques to improve a patient's functional ability to perform activities of daily living.

Optometrist — A doctor of optometry (O.D.) licensed to examine and test eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids.

Orthopedic appliance — An individualized rigid or semirigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

Outpatient services — Medical/surgical services received in the outpatient department of a hospital, emergency room, ambulatory surgical facility, free-standing dialysis facility, or other covered outpatient treatment facility.

Participating provider — Any provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross Blue Shield (BCBS) Plan, or the national BCBS transplant network. Your "preferred" provider may have two agreements with the local BCBS Plan — a "preferred" contract and another "participating" provider contract. Providers that have only the "participating" provider contract are **not** considered preferred providers. See "Provider," on the next page.

Physical rehabilitation — Occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. (This does not include substance abuse rehabilitation.)

Physical therapist — A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body. A physical therapist treats disease or accidental injury by physical and mechanical means (regulated exercise, water, light, or heat).

Physical therapy — The use of physical agents to treat disability resulting from disease or injury. Physical agents include heat, cold, electrical currents, ultrasound, ultraviolet radiation, and therapeutic exercise.

Physician — A practitioner of the healing arts (doctor of medicine or osteopathy only) who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Podiatrist — A licensed doctor of podiatric medicine (D.P.M.). A podiatrist treats conditions of the feet.

Practitioner of the healing arts — Any physician, professional provider, or other person holding a license or certificate provided for in Chapter 61, Article 4, 5, 6, or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on, or prescribe for any human pain, injury, disease, deformity or physical or mental condition.

Preferred provider or preferred specialist — See "Provider," on the next page.

Pregnancy-related services — See "Maternity," earlier in this section.

PPO Primary Provider (PPP) — See "Provider," on the next page.

Prior approval — A requirement that you or your provider must obtain authorization from BCBSNM before you are admitted as an inpatient (admission review approval) and before you receive certain types of services (other prior approvals).

Prosthesis or prosthetic device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed hospital, physician, or other professional provider authorized to furnish health care services within the scope of licensure.

- **Health care facility:** An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a home health care agency, a diagnostic lab or imaging center, and a rehabilitation or other therapeutic health setting.
- **Physician:** A practitioner of the healing arts who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.
- **Practitioner of the healing arts:** A physician or other health care practitioner, including (for example) a pharmacist, chiropractor, dentist or oral surgeon, optometrist, or registered nurse in expanded practice, or a podiatrist who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

This Plan includes two different networks of providers. A provider may belong to one or more networks, but if you want to visit a network provider, you must choose the provider from the *appropriate* network:

- **Exclusive BCBSNM transplant provider:** A provider that, for the transplant being provided, contracts directly with BCBSNM or through the BCBSNM national transplant network. Transplants are covered only if received at a facility that is in the exclusive BCBSNM transplant network.
- **Preferred provider:** A provider that has a special contract with BCBSNM to provide health care for members enrolled in a "Preferred Provider Option (PPO)" health care plan.
  - **PPO Primary Provider (PPP):** A preferred provider in one of the following medical specialties **only:** Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery, or Pediatric Allergy.
  - **PPO Specialist:** A health care practitioner who has a preferred provider contract with his/her BCBS Plan and who is **not** a "PPP" as defined above. A specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care service providers.

A network provider agrees to provide health care services to members with an expectation of receiving payment (other than copayments, coinsurance, or deductibles) directly or indirectly from BCBSNM (or other entity with whom the provider has contracted). A network provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this Plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. BCBSNM (or other contracting entity) will pay the network provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific network providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.

Psychiatric hospital — A psychiatric facility licensed as an acute care facility or a psychiatric unit in a medical facility that is licensed as an acute care facility. Services are provided by or under the supervision of an organized staff of physicians.

Continuous 24-hour nursing services are provided under the supervision of a registered nurse.

Pulmonary rehabilitation — An individualized, supervised physical conditioning program. Occupational therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Radiation therapy — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Reconstructive surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect.

Registered nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is licensed by appropriate state authority.

Rehabilitation hospital — An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of physical, occupational, speech, and respiratory therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or accidental injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Residential treatment center — An institution that specializes in the treatment of mental illness, alcohol or drug abuse, or other related illness, provides residential treatment programs and is licensed in accordance with the laws of the appropriate legally authorized agency.

Respiratory therapist — A person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

Routine newborn care — Care of a child immediately following his/her birth that includes: routine hospital nursery services; alpha-fetoprotein IV screening; routine medical care in the hospital after delivery; pediatrician standby care at a C-section procedure; and services related to circumcision of a male newborn.

Routine patient care cost — For purposes of the cancer clinical trial benefit described in *Section 4*, a "routine patient care cost" means a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment, or an FDA-approved drug provided to you during a cancer clinical trial, but only to the extent that the drug is not paid for by the manufacturer, distributor, or provider of the drug. **Note:** For a covered cancer clinical trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition. A "routine patient care cost" does **not** include the cost of any investigational drug, device, or procedure, the cost of a non-health care service that you must receive as a result of your participation in the clinical trial, costs for managing the research, costs that would not be covered or that would not be rendered if non-investigational treatments were provided, or costs paid or not charged for by the trial providers.

Routine/preventive care — Services received for the early detection of conditions for which the patient does not currently have symptoms and to prevent illness or other conditions. For example, if you go to the doctor for a colonoscopy and you do not have symptoms of any problem or a family history of any problems with the intestines, it is usually a "routine" colonoscopy. But if the doctor finds a possible problem and does surgery during the exam (such as removing polyps or taking a biopsy), the exam will be billed as a **non-**routine colonoscopy. In this case, because surgery was done, you would pay the copayment for an outpatient surgical procedure. Also, if you are having digestive problems, for example, and the doctor performs a colonoscopy in order to help diagnose your condition, the colonoscopy is a **non**-routine, diagnostic surgical procedure and you would also pay the copayment for an outpatient surgery. (Endoscopic procedures, including colonoscopies, are billed as surgical procedures and are covered under the surgery benefit unless **strictly** for routine/preventive purposes. See definition of "Surgical services," on the next page.)

Skilled nursing care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (LPN) or registered nurse (RN).

Skilled nursing facility — A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; *and*
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disease, or tuberculosis, or for intermediate, custodial, or educational care.

Special care unit — A designated unit that has concentrated facilities, equipment, and supportive services to provide an intensive level of care for critically ill patients. Examples of special care units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit, and isolation room.

Speech therapist — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

Subscriber — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of a direct-pay contract, the person in whose name the contract/ID card is issued. The term "subscriber" may also encompass other persons in a nonemployee relationship with the employer, group, or business if specified in the Professional Services Agreement (e.g., COBRA members).

Substance abuse — A condition defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol and/or other drugs. There may also be significant risk of severe withdrawal symptoms if the use of alcohol, drug, or other substance is discontinued. Drug abuse does not include the abuse of alcohol or nicotine addiction. Substance abuse may also be referred to as "chemical dependency."

Summary of Benefits — The schedule, beginning on page iv, that defines your copayment, deductible, coinsurance, and out-of-pocket requirements, annual and lifetime benefit limitations, and provides an overview of covered services.

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

Temporomandibular joint (TMJ) syndrome — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Tertiary care facility — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth), and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This hospital unit also has responsibilities for coordination of transport, communication, and data analysis systems for the geographic area served.

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

Transplant-related services — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant, and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant.

Urgent care — Medically necessary health care services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Utilization review — A system for reviewing the appropriate and efficient allocation of medical services and hospital resources given or proposed to be given to a patient or group of patients.

Well-child care — Periodic health and developmental assessments and screenings, immunizations, and physical exams provided to children who have no symptoms of current illness as recommended by the American Academy of Pediatrics, the state of New Mexico, and the U.S. Preventive Services Task Force.

Continuation Coverage Rights Under COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under the group health care plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger group employers. COBRA continuation coverage may be available to you and to other members of your family who are covered under the health care plan when you would otherwise lose your group health coverage. Contact the employer to determine if you or your group are eligible for COBRA continuation coverage.

This notice generally explains:
- COBRA continuation coverage;
- When it may become available to you and your family if your group is subject to the provisions of COBRA, and
- What you need to do to protect the right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about rights and obligations under the Plan and under federal law, contact the Plan Administrator or see *Section 3* of this benefit booklet.

The Plan Administrator of the Plan is named by the employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact your Plan Administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA Administrator for specific information for your Plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:
- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens and if your group is subject to the provisions of COBRA:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Administrator within 30 days when the qualifying event is:
- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- With respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:
- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A dependent child losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended:

Disability Extension of 18-month Period of Continuation Coverage — If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that your Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of

COBRA continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage — If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

If You Have Questions

If you have questions about COBRA continuation coverage, contact the Plan Administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan Administrator.

Notes

Acceptance of coverage under this benefit booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this benefit booklet.

The legal agreement between the State of New Mexico and Blue Cross and Blue Shield of New Mexico (referred to as BCBSNM) includes the following documents:

- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the subscriber and his/her dependents; and
- the members' identification cards.

In addition, the State of New Mexico has important documents that are part of the legal agreement:

- the Professional Services Agreement between BCBSNM and the State of New Mexico
- the "Request for Proposal" and BCBSNM's response to it

The above documents constitute the entire legal agreement between BCBSNM and the State of New Mexico. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions. You will be notified of any changes to this benefit booklet at least 30 days before the changes become effective.

The State of New Mexico reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This benefit booklet is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Professional Services Agreement.

BlueCross BlueShield of New Mexico

Web site: www.bcbsnm.com
Street address: 4373 Alexander Blvd., NE
Mailing address: P.O. Box 27630
Albuquerque, New Mexico 87125-7630

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