BlueCross BlueShield of New Mexico









Your Health Care Benefits Program

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield

Albuquerque Public Schools

Account #: L04121

BlueNet EPO℠

A Guide To Your Group Preferred Provider (EPO) Health Care Plan

L04121 (January 1, 2025)

IMPORTANT NOTICE

For all plans with an effective date of January 1, 2020, or later:

1. Cost-sharing and benefits limitations for an Emergency Health Care Service rendered by a Nonparticipating Provider shall be the same as if rendered by a Participating Provider. Prior authorization shall not be required for Emergency Health Care Services.

2. Cost-sharing and benefits limitations for a Medically Necessary, non-emergent Health Care Service rendered by a Nonparticipating Provider at a Participating Facility where the covered person had no ability or opportunity to choose to receive the service from a Participating Provider shall be the same as if the service was rendered by a Participating Provider.

3. Cost-sharing and benefits limitations for a Medically Necessary, non-emergent Health Care Service where no Participating Provider is available to render the service shall be the same as if the service was rendered by a Participating Provider. To inquire about benefits under this provision, you or your Provider must call the BCBSNM Health Services department **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. See *Section 4: Utilization Management* for details.

CUSTOMER ASSISTANCE

Customer Service: — The 24/7 Nurseline can help when you have a **health** problem or concern. The 24/7 Nurseline is staffed by Registered Nurses who are available 24 hours a day, 7 days a week.

24/7 Nurseline toll-free telephone number: 1-800-973-6329

When you have a **non-medical** benefit question or concern, call BCBSNM Monday through Friday from 6 A.M. - 8 P.M. and 8 A.M. - 5 P.M. on Saturdays and most holidays or visit the BCBSNM Customer Service department in Albuquerque. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.) You may either call toll-free or visit the BCBSNM office in Albuquerque at:

Street address: 4373 Alexander Blvd. NE 87107
Toll-free telephone number: 1-888-371-1928

Send all **written inquiries/Prior Authorization requests** and submit **medical/surgical Claims*** to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 660058
75266-0058

Prior Authorizations: Medical/Surgical Services—For Prior Authorization requests, call a Health Services representative, Monday through Friday 8 A.M. - 5 P.M., Mountain Time. Written requests should be sent to the address given above. **Note:** If you need Prior Authorization assistance between 5 P.M. and 8 A.M. or on weekends, call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

1-505-291-3585 or 1-800-325-8334

Mental Disorder and Chemical Dependency—For inquiries or Prior Authorizations related to Mental Disorder or Chemical Dependency services, call the Behavioral Health Unit (BHU):

24 hours/day, 7 days/week: 1-888-898-0070

Send Claims* to:

Claims, Behavioral Health Unit
P.O. Box 660058
75266-0058

Website—For Provider network information, Claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM website at:

www.bcbsnm.com

***Exceptions to Claim Submission Procedures**—Claims for Health Care Services received from Providers that do not contract **directly** with BCBSNM, should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. **Note: Do not submit drug plan claims to BCBSNM; submit these to the pharmacy benefit manager for Albuquerque Public Schools.** See *Section 8: Claims Payments and Appeals* for details on submitting claims.

Albuquerque Public Schools
Employee Benefits Department
(505) 889-4859
Employee.benefits@aps.edu
http://www.aps.edu/human-resources/benefits

Be sure to read this Benefit Booklet carefully and refer to the *Plan Highlights*.

A message from

Albuquerque Public Schools

Welcome to the EPO health care benefit plan for eligible employees of **Albuquerque Public Schools** and their Eligible Family Members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **Albuquerque Public Schools** self-funded Health Care Benefit plan. You will be accessing the BCBS Provider network as if you were insured by BCBSNM.

Please take some time to get to know your Health Care Benefit Plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. Learning how this plan works can help make the best use of your Health Care Benefits.

Note: This Plan's benefit administrator (BCBSNM) and **Albuquerque Public Schools** (your group) may change the benefits described in this Benefit Booklet. If that happens, BCBSNM or **Albuquerque Public Schools** will notify you of those mutually agreed upon changes.

If you have any questions once you have read this Benefit Booklet, call us at the number listed on the back of your ID Card, or as listed in *Customer Assistance* on the preceding page. You may also contract the APS Employee Benefit Department. It is important to all of us that you understand the protection this coverage gives you.

Thank you for selecting BCBSNM for your health care coverage. We look forward to working with you to provide personalized and affordable health care now and in the future.

Note: Exclusive Provider Organization (EPO) – This EPO Plan provides In-Network ONLY coverage on a Nationwide basis. This means that you must use Preferred or Participating Providers contracted with Blue Cross Blue Shield. The BCBSNM network is one of the largest in the state of New Mexico, and you will also be able to take advantage of the many Participating Provider contracts that other Blue Cross Blue Shield Plans have throughout the United States. On this EPO Plan, you will not have coverage for services from Nonpreferred or Nonparticipating Providers (those healthcare providers and facilities that do not contract with BCBS) except in emergency and urgent care situations.

Sincerely,

Albuquerque Public Schools

TABLE OF CONTENTS

PLAN SUMMARY

The employer has established and maintains a self-insured Plan of comprehensive health care benefits (called the *Plan*) for its eligible employees and other persons as designated in its personnel policy.

The Plan is operated under an Administrative Services Agreement between the employer and Blue Cross and Blue Shield of New Mexico, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (called the Claims Administrator).

Under this Agreement we provide benefits on behalf of the employer in accordance with the terms of the Plan and performs certain other services on behalf of the employer. The employer reserves the right to amend or cancel any or all provisions of the Plan at any time as it relates to any covered persons.

We provide administrative claims payment services only and do not assume any financial risk or obligation with respect to claims.

This benefit booklet is issued according to the terms of the Plan. It is not a summary Plan description. It is only a summary of benefits, and all statements in this Benefit Booklet are subject to the terms of the Plan documents on file in the Albuquerque Public Schools Benefits Department.

This benefit booklet replaces any and all summaries, certificates or benefit booklets previously issued for the employees under the Plan. It describes the Plan in effect as of the date agreed upon between the employer and us for all covered person (called “you” or “your”).

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This Benefit Booklet describes the medical/surgical, and Mental Disorder/Chemical Dependency coverage available to Members of this health care plan and the Plan's benefit limitations and exclusions.

- Always carry your current Plan ID Card issued by BCBSNM. When you arrive at the Provider's office or at the Hospital, show the receptionist your Plan ID Card.
- To find Doctors and Hospitals nearby, you may use the Internet, make a phone call, or request a hard copy of a directory from BCBSNM. See details in *Section 3: How Your Plan Works.*
- Call BCBSNM (or the Behavioral Health Unit) for Prior Authorization, if necessary. The phone numbers are on your Plan ID Card. See *Section 4: Utilization Management* for details about the Prior Authorization process.
- Please read this Benefit Booklet and familiarize yourself with the details of your Plan *before* you need services. Doing so could save you time and money.
- **In an Emergency, call 911 or go directly to the nearest Hospital.**

DEFINITIONS

Throughout this Benefit Booklet, many words are used that have a specific meaning when applied to your health care coverage. When you come across these terms while reading this Benefit Booklet, please refer to *Section 10: Definitions,* for an explanation of the limitations or special conditions that may apply to your benefits.

PLAN HIGHLIGHTS

The *Plan Highlights* is available on the Albuquerque Public Schools Benefits Department website or by calling BCBSNM, and may be referred to as the Summary of Benefits in this Benefit Booklet and other benefit plan literature. The *Plan Highlights* shows specific Member cost-sharing amounts and coverage limitations of the APS plan. A new *Plan Highlights* will be issued each year or when changes are made to the APS health plan.

IDENTIFICATION (ID) CARD

You will receive a BCBSNM Identification (ID) Card. The ID Card contains your "Group" number and your identification number (including an alpha prefix) and tells Providers that you are entitled to benefits under this health care plan with BCBSNM.

Carry it with you. Do not let anyone who is not named in your coverage use your card to receive benefits. If you need an additional card or need to replace a lost card, contact a BCBSNM Customer Service Advocate.

PROVIDER NETWORK DIRECTORY

The Provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all Providers and their qualifications in the BCBSNM Exclusive Provider (EPO) network. 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. 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 the directory, contact a Customer Service Advocate or visit the BCBSNM website.

ACCESS PLAN

If required by applicable law, BCBSNM's access plan is available upon request, free of charge electronically, but printed copies are subject to charges for reasonable production and, if applicable, delivery costs.

DRUG PLAN BENEFITS

Albuquerque Public Schools has Contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits. Refer to information you received from the APS pharmacy benefit manager or contact the APS Employee Benefits Department with questions about your prescription drug benefits.

BLUECARD® BROCHURE

As a Member of a health plan administered by BCBSNM, you take your health plan benefits with you – across the country and 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 and Blue Shield (BCBS) Plans. You and your Eligible Family Members 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. To find a Preferred Provider outside New Mexico, you can visit the BCBSNM website at www.bcbsnm.com and click on Find Care.

LIMITATIONS AND EXCLUSIONS

Each provision in *Section 5: Covered Services* not only describes what is covered but may list some limitations and exclusions that specifically relate to a particular type of service. *Section 6: General Limitations and Exclusions* lists limitations and exclusions that apply to *all* services.

PREFERRED PROVIDER BENEFIT ONLY

Some services are eligible for benefits **only** when received from Preferred Providers. Refer to your *Plan Highlights* for specific details.

PRIOR AUTHORIZATION REQUIRED

To receive full benefits for some non-Emergency Admissions and certain medical/surgical services, you or your Provider must call the BCBSNM Health Services department **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. See *Section 4: Utilization Management* for details. **Note:** Call Customer Service if you need Prior Authorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive full benefits for Emergency Hospital Admissions, you (or your Provider) should notify BCBSNM **within 48 hours** of Admission, 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. Also, if you have a routine delivery 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 Prior Authorization before you are discharged.

Written Request Required

If a **written request** for Prior Authorization is required in order for a service to be covered, you or your 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 660058
Dallas, TX 75266-0058

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.

PRIOR AUTHORIZATION OF BEHAVIORAL HEALTH CARE

Prior Authorization must be obtained for all Inpatient and specified Outpatient Mental Disorder and Chemical Dependency services by the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID Card). For services requiring Prior Authorization, you or your Physician should call the BHU before you schedule treatment. For services received in an emergency room, call the BHU within 48 hours of admission or, if the patient's condition makes it impossible to call within 48 hours, as soon as possible. The BHU will coordinate Covered Services

with an In-Network Provider near you. **If you do not call and receive Prior Authorization before receiving non-Emergency services, benefits for services may be denied**. Call 7 days a week, 24 hours a day:

Toll-Free Phone Number: 1-888-898-0070

PRIOR AUTHORIZATION AND COMPLAINT/APPEAL PROCEDURES

In addition to the summary of complaint and appeal procedures presented in this booklet, Appendix B: Notice - Inquiries/Complaints and Internal/External Appeals for Self-Funded Plans provides all of the details of the BCBSNM complaint and appeals procedures, including independent external review and other actions that may be available under your health plan.

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

BCBSNM and your employer have the right to offer programs for the purposes of medical management programs, quality improvement programs, and health behavior wellness, maintenance or improvement over and above the standard benefits provided by this Plan. These programs may allow for a reward, a contribution, a disincentive, a differential in premiums or a differential in medical, Prescription Drug or equipment Copayments, Coinsurance, Deductibles or costs, or a combination of incentives and/or disincentives for participation in any program offered or administered by BCBSNM or any retailer, Provider, or manufacturer chosen by **Albuquerque Public Schools** or BCBSNM to administer such program. Discount programs for various health behavior wellness or insurance-related items and services may also be available from time to time. For details of current discounts or other programs available, please contact a Customer Service representative by calling the phone number on the back of your ID Card. Such programs may be discontinued with or without notice. Contact the **Albuquerque Public Schools** Employee Benefits Department for additional information regarding any value-based programs offered by your employer.

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse status and unless otherwise permitted by law. APS will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

VIRTUAL VISITS

Covered Services provided via consultation with a Virtual Visit Provider, powered by MDLive, through interactive video via online portal or mobile application. Virtual Visits provide access to MDLive Board Certified Providers who can provide diagnosis and treatment of non-Emergency Medical conditions, Mental Disorder and Chemical Dependency conditions in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit. Member Cost Share for Virtual Visits with MDLive will be no charge on the APS plan for Medical and Behavioral Health services.

TELEMEDICINE MEDICAL SERVICES

Covered Services provided via consultation with a contracted Provider through information and telecommunication technology. Telemedicine provides access to Providers who can provide diagnosis and treatment of non-Emergency medical conditions, Mental Disorders and Chemical Dependency in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit.

See your *Summary of Benefits* for the member cost share for Telemedicine for primary care office visits and for Mental Disorder and Chemical Dependency visits delivered via Telemedicine.

IDENTITY THEFT PROTECTION SERVICES

As a Member, BCBSNM makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSNM's designated outside vendor and acceptance or declination of these services is optional to Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsnm.com or telephonically by calling the toll free telephone number on your Identification Card. Services may automatically end when the person is no longer an eligible Member. Services may change or be discontinued at any time with or without notice and BCBSNM does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

CUSTOMER SERVICE

If you have any questions about your coverage, call or e-mail BCBSNM's Customer Service department. Customer Service Advocates are available Monday through Friday from 6 A.M. - 8 P.M. and 8 A.M. - 5 P.M., Mountain Time on Saturdays and most holidays. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with Prior Authorization requests.
- check on a Claims status.
- order a replacement ID Card, Provider directory, Benefit Booklet, or forms.

For your convenience, the toll-free customer service number is printed at the bottom of every page in this Benefit Booklet. Refer to Customer Assistance at the front of this booklet for important phone numbers, website, and mailing information. You can also e-mail the Customer Service unit via the BCBSNM website noted below:

In addition to accepting e-mail inquiries, the BCBSNM website contains valuable information about BCBSNM Provider networks, and other Plan benefits. It also has various forms you can print off that could save you time when you need to file a Claim.

Website: www.bcbsnm.com

Behavioral Health Customer Service

When you have questions about your Mental Disorder and Chemical Dependency benefits, call the BCBSNM Behavioral Health Unit (BHU) for assistance.

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

Deaf, hard-of-hearing, and speech disabled callers may use the New Mexico Relay Network. Dialing **711** connects the caller to the state transfer relay service for TTY and voice calls.

Translation Assistance

If you need help communicating with BCBSNM, BCBSNM offers Spanish bilingual interpreters for Members who call Customer Service. If you need multilingual services, call the Customer Service phone number on the back of your ID Card.

After Hours Help

If you need or want help to file a complaint outside normal business hours, you may call Customer Service. Your call will be answered by an automatic phone system. You can use the system to:

- leave a message for BCBSNM to call you back on the next business day.
- leave a message saying you have a complaint or appeal.
- talk to a nurse at the 24/7 Nurseline right away if you have a health problem.

24/7 Nurseline

If you can't reach your Doctor, the free 24/7 Nurseline will connect you with a nurse who can help you decide if you need to go to the Emergency room or Urgent Care center, or if you should make an appointment with your Doctor. The Nurseline will also give you advice if you call your Doctor and he or she can't see you right away when you think you might have an urgent problem. To learn more, call:

Toll-free: 1-800-973-6329

BCBSNM also has a phone library of more than 1000 health topics available through the Nurseline, including over 600 topics available in Spanish.

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

Albuquerque Public Schools determines eligibility for employees and their family members, and enrollment procedures. In order to have a complete view of your medical plan benefits as an APS employee, in addition to this benefits booklet you need to obtain a copy of the APS Employee Benefits Enrollment Guide which is available on the APS website at http://www.aps.edu/human-resources/benefits or from the APS Employee Benefits Department. Important eligibility and enrollment information is included in this APS document. Every effort has been made to ensure that the information in this booklet matches the information in the APS Employee Benefits Enrollment Guide. However, if there are discrepancies between this booklet and the APS document, the APS document supersedes this booklet. No eligibility rules or variations in premium will be imposed on you based on your specific health status, medical condition, Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, or perceived disability, blindness, partial blindness, limb loss or limb absence, age, sex, gender identity or sexual orientation. Variations in the administration, processes, or benefits of this policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

See “Re-Enrollment” in this section for important information if you or an Eligible Family Member were previously enrolled in a health care plan administered by BCBSNM.

ELIGIBLE FAMILY MEMBERS

- Be wary of offers to waive Copayments, Deductibles, or Coinsurance. These costs are passed on to you or to the APS medical plan eventually.
- Be wary of mobile health testing labs. Ask what your health plan 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 Advocate.
- Be very cautious about giving information about your health plan over the phone.

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

BLUE ACCESS FOR MEMBERS[SM]

To help Members track Claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan Members. The online “Blue Access for Members” (BAM) tool provides convenient and secure access to Claim information and account management features and the Cost Estimator tool. While online, Members can also access a wide range of health and wellness programs and tools, including a health assessment and personalized health updates. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members and create a user ID and password for instant and secure access.

If you need help accessing the BAM site, call:

BAM Help Desk (toll-free): 1-888-706-0583
Help Desk Hours: Monday through Friday 6 A.M. - 9 P.M., Mountain Time
Saturday 6 A.M. - 2:30 P.M. Mountain Time

Note: Depending on your Group's coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID Card. BCBSNM uses data about program usage and Member feedback to make changes to online tools as needed. Therefore, programs and their rules are updated, added, or terminated, and may change without notice as new programs are designed and/or as our Members' needs change. We encourage you to enroll in BAM and check the online features available to you - and check back in as frequently as you like. BCBSNM is always looking for ways to add value to your health care plan and hope you will find the website helpful.

Covered family member, covered spouse, covered child - An eligible spouse or Eligible Child (as defined below) who has applied for and been granted coverage under the Subscriber's policy based on his/her family relationship to the Subscriber.

Eligible Family Members - Family members of the Subscriber, limited to the following persons:

- the Subscriber's legal **spouse**
- the Subscriber's Eligible **Child** through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and premium contribution adjusted if needed - unless the child is an Eligible Family Member under this Plan due to a disability as described below.)
- the Subscriber's **unmarried** child age 26 or older who was enrolled as the Subscriber's covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled,** chiefly dependent upon the Subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability. Such condition must be certified by a Physician and BCBSNM. Also, a child may continue to be eligible for coverage age 26 or older only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition within 31 days of the child's attainment of the limiting age and subsequently, as may be required by BCBSNM, but not more frequently than annually after the two-year period following the child's attainment of the limiting age of 26.
- the Subscriber's **Domestic Partner** - a person of the same or opposite gender who meets the Albuquerque Public Schools qualifying criteria as a Domestic Partner. Visit or contact the APS Employee Benefits Department for more information and to obtain a copy of the Affidavit of Domestic Partnership that must be completed and submitted to the APS Employee Benefits Department to determine possible eligibility for Domestic Partner coverage. The federal government does not recognize Domestic Partners as qualified Eligible Family Members and therefore, the premium paid for their coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the employer for the Domestic Partner and his/her covered children. Employees wanting to change benefit elections involving a Domestic Partner must adhere to the same rules regarding qualifying events.

Eligible Child - The following family members of the Subscriber through the end of the month during which the child turns age 26:

- natural or legally adopted child of the Subscriber
- child placed in the Subscriber's home for purposes of adoption (including a child for whom the Subscriber is a party in a suit in which the adoption of the child by the Subscriber is being sought)
- stepchild of the Subscriber (or otherwise Eligible Child of a Domestic Partner, if Domestic Partners are covered under your benefit plan)
- child for whom the Subscriber must provide coverage because of a court order or administrative order pursuant to state law

A child meeting the criteria above is an "Eligible Child" whether or not the Subscriber is the custodial or noncustodial parent, and whether or not the Eligible Child is claimed on income tax, employed, married, attending school or residing in the Subscriber's home, **except** that:

- once the Subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, or stepchild of the Subscriber in order to retain eligibility as a family member under this health plan.

Within 60 days of hire, you must submit all required forms to the APS Employee Benefits Department. Once you have made an election during your initial enrollment period of 60 days from your date of hire, you are locked into that decision until the next annual open enrollment period, unless you have a permissible change in your status (as permitted by the IRS) affecting your benefit eligibility.

BCBSNM may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, marriage and/or birth certificate, or court orders) that an individual qualifies as an Eligible Family Member under this coverage. Unless listed as an Eligible Family Member, no other family member, relative or person is eligible for coverage as a family member. Common-law spouses are **not** considered legal spouses; in order to be considered eligible for coverage, a common-law spouse must meet the definition of "Domestic Partner."

Information for Noncustodial Parents

When a child is covered by the Plan through the child's noncustodial parent, then **Albuquerque Public Schools** will:

- provide such information to the custodial parent as may be necessary for the child to obtain benefits through the **Albuquerque Public Schools** Plan;
- permit the custodial parent or the Provider (with the custodial parent's approval) to submit Claims for Covered Services with the approval of the noncustodial parent; and
- make payments on Claims submitted in accordance with the above provision directly to the custodial parent, the Provider, or the state Medicaid agency as applicable.

MEDICARE-ELIGIBLE MEMBERS

Shortly before you turn age 65 or qualify for Medicare benefits for other reasons, you are responsible for contacting the local Social Security office to establish Medicare eligibility. You may also contact the APS Employee Benefits Department to discuss coverage options.

If an active employee qualifies under the provisions of federal law for the working aged (TEFRA), then the working employee age 65 or older and/or his/her eligible spouse age 65 or older who is covered by Medicare may continue this Plan coverage as primary over Medicare until the eligible employee retires or terminates employment with APS.

A Member under age 65 receiving Medicare benefits due to disability or end-stage renal disease (ESRD) also has primary benefits under this Plan coverage, but for only a limited period of time. (For ESRD patients, this Plan coverage is primary only during the CMS-defined ESRD coordination time period - usually 30 months after the start of dialysis. Medicare becomes primary when the Medicare ESRD coordination time period expires.)

In any case, if you are a Medicare beneficiary and you actively *select* Medicare as your primary coverage, this Plan is **not** available to you, and your employer may not offer you any other employer-sponsored health care plan.

Refer to a Medicare Handbook or contact the Social Security Administration for more information and eligibility guidelines that apply to you.

APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her Eligible Family Members (and/or Domestic Partner), by submitting an enrollment/change form via Winocular to the **Albuquerque Public Schools Employee Benefits Department within 60 days** after becoming eligible according to the terms of the APS Employee Benefits Enrollment Guide**. Note: Albuquerque Public Schools** cannot use genetic information or require genetic testing in order to determine or to limit or deny coverage.

WHEN COVERAGE BEGINS

Albuquerque Public Schools will determine your Effective Date of Coverage according to APS Employee Benefits Enrollment Guide.

This Plan does not cover any service received before your Effective Date of Coverage (which, for Eligible Family Members, may be later than the Subscriber's effective date). Also, if your prior coverage has an extension of benefits provision, this Plan will not cover those charges incurred after your effective date that are covered under the prior benefit plan.

CHANGES TO COVERAGE

After initial enrollment, you may need to add Eligible Family Members to, or remove them from your coverage, update your address, or switch from Individual to Double or Family coverage, or vice versa.

Your ability to change coverage types (e.g., from Family to Double or Individual coverage, etc.) will depend on the rules and regulations set forth by the IRS and APS. Please contact the APS Employee Benefits Department to find out when you can change your coverage type or remove a person from your coverage.

ADDING A FAMILY MEMBER TO COVERAGE

A Subscriber may apply for coverage of an Eligible Family Member (such as a new spouse or a newborn child). **Within 60 days** of acquiring the newly Eligible Family Member, the Subscriber must:

- complete and submit via Winocular all necessary enrollment/change forms and legal documentation of proof of dependency, and
- pay any additional premium or other employee contribution for coverage, which may mean changing, for example, from Individual to Double or to Family coverage.

Adding a Spouse or a Domestic Partner

If a Subscriber adds coverage for a spouse **within 60 days** of marriage, the effective date of the new Eligible Family Member's coverage will be the first of the month following the date APS receives via Winocular the completed and signed enrollment/change form. If the Subscriber does not submit a completed and signed enrollment/change form to APS (or to the COBRA administrator), along with necessary documentation **within 60 days** of marriage, the spouse may not be added to coverage except during switch/open enrollment (or as specified under "Special Enrollment" later in this section).

Domestic Partners and their Eligible Children may be added to existing coverage only during the annual switch/open enrollment period or due to a loss of other coverage.

Adding an Eligible Child

If you do not submit via Winocular an enrollment form for an Eligible Child within the time frames below, the child will be considered a **late applicant**, except as specified under "Special Enrollment."

Newborn Children

You must enroll for coverage for the newborn **within 60** days of the birth in order for newborn care to be covered. You must also pay any required additional premium for the child. The Effective Date of Coverage for a newborn is the child's date of birth.

Note: If the parent of the newborn is an Eligible Child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), benefits are **not** available for the newborn.

Adopted Children

A child placed in the Subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. Enrollment for coverage must be made within **60 days** following legal adoption. (An adopted child is covered as any other child, subject to the same Eligible Child age limitations and restrictions.) **The Effective Date of Coverage for an adopted child is the date the child is adopted or placed for adoption, whichever occurs first.**

Legal Guardianship

Enrollment for coverage must be made for a child for whom the Subscriber or the Subscriber's spouse becomes the legal guardian **within 60 days** of the court or administrative order granting guardianship.

Stepchild

Enrollment for coverage must be made for a stepchild **within 60 days** of the marriage to the stepchild's biological parent.

Court Ordered Coverage for Children

When an employee or employer is required by a court or administrative order to provide coverage for an Eligible Child, the Eligible Child may be enrolled in the Subscriber's Family coverage, or Employee/Children coverage. (The Subscriber may be required to pay additional premium in order for the Eligible Child to be added.) If not specified in the court or administrative order, the Eligible Child's Effective Date of Coverage will be the date the order has been filed as public record with the State or the first of the month following receipt, via Winocular, by the APS Employee Benefits office of the completed Enrollment Form, whichever is later. **Albuquerque Public Schools** must receive a copy of the court or administrative order.

LATE APPLICANT

Unless eligible for a Special Enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 60 days** of becoming eligible for coverage under this Plan (e.g., a newborn child added to coverage more than 60 days after birth, a child added more than 60 days after legal adoption, or a new spouse or stepchild added more than 60 days after marriage)
- anyone eligible but not enrolled during his or her initial enrollment eligibility
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under USERRA of 1994)

SWITCH/OPEN ENROLLMENT

Switch/Open Enrollment is the period prior to the APS anniversary date of January 1st when eligible employees may make changes to their coverage elections. During the annual Switch/Open Enrollment period, any eligible employee may enroll his/herself and his/her Eligible Family Members as members under this Plan; eligible employees may also elect to move to one of the other APS health plan options, or may drop coverage for themselves and/or their family members. APS generally holds Switch/Open Enrollment in October for coverage or changes effective January 1st of the following year.

SPECIAL ENROLLMENT FOR ACTIVE EMPLOYEES AND THEIR COVERED FAMILY MEMBERS

There are four instances ("qualifying events") in which an eligible person can obtain a "Special Enrollment" right (see definition in *Section 10: Definitions).* You have a limited amount of time during which you may request a Special Enrollment. If you do not request Special Enrollment and complete the APS enrollment process **within 60 days of the qualifying event,** you will be considered a late applicant.

Note: There are no Special Enrollments for persons applying for any continuation (or conversion) (COBRA) coverage. You must enroll in these coverages timely.

Qualifying Events

The four instances of Special Enrollment are Loss of Prior Coverage, Change in Family Status, Loss of Medicaid/SCHIP Eligibility, and Medicaid/SCHIP Group Health Plan Premium Assistance Eligibility. Refer to the APS Employee Benefits Enrollment Guide for more information regarding your eligibility to enroll in the APS medical plan due to a qualifying event.

Waiving Coverage

If an employee declines to enroll in the APS health plan when initially eligible to do so, the employee is encouraged to submit an enrollment form via Winocular to the APS Employee Benefits Department indicating "Waive Coverage". However, failure to submit an enrollment form that indicates waiving/declining the APS coverage (within 60 days of an employee's initial eligibility date or Special Enrollment eligibility date) will also result in waiving/declining the coverage. If, at a later date, the employee wants the coverage that was waived or declined, enrollment is only allowed due to a Special Enrollment event or during the next Switch/Open Enrollment period.

If you do not enroll an Eligible Family Member when he/she is initially eligible, you do not need to submit any documentation to APS. However, if the affected family member later loses the other coverage and you request a Special Enrollment, you *will* need to submit proof that the family member had that other coverage.

If the person declining coverage later requests a Special Enrollment, but no such proof of loss of prior coverage is provided, he/she will be ineligible for Special Enrollment (unless a change in family status also applies).

Coverage Effective Date

If a Member is granted a Special Enrollment due to involuntary loss of coverage, due to premium assistance eligibility, or due to marriage, and all required documentation is received timely via Winocular by the APS Employee Benefits Department, coverage will begin the first day of the month after APS receives the completed enrollment form and any required supporting documentation. However, for a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption, provided that all required documentation is received timely by the APS Employee Benefits Department.

If a completed and signed enrollment/change form is **not** received within the time periods set forth in this section, the employee and /or his /her Eligible Family Members will be considered late applicants and no Special Enrollment right will be available.

RE-ENROLLMENT

If a previously covered employee and/or Eligible Family Member is re-enrolled in this group Plan, he/she will usually be considered a late applicant. See "Leave of Absence or Military Service" and "Special Enrollment" for exceptions and details.

Any individual whose previous BCBSNM contract was terminated for Good Cause is not eligible to re-enroll in this Plan, unless approved in writing by BCBSNM.

If coverage is voluntarily discontinued by a COBRA Member, the terminated Member may not re-enroll at any time.

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The APS employee/Subscriber must notify Albuquerque Public Schools as soon as possible but not more than 60 days following any changes that may affect his/her or a family Member's coverage or eligibility. (Note: APS sends BCBSNM a weekly file with enrollment information for this plan. If employee or family Member information is incorrect in the APS system, it will also be incorrect in the BCBSNM system. This may result in delayed or lost health plan Identification Cards, and problems with payment of claims.)

Employee name, address or phone number changes - Update your address or phone number using the Employee Self-Service feature on Infor Lawson, or contact the Employee Data Center Specialist assigned to your location (visit https://www.aps.edu/human-resources/employee-data-center). You may also complete a Change Form in the APS Human Resources Department (6400 Uptown Blvd NE, Suite 210E, Albuquerque, NM 87110). Contact your assigned Data Center Specialist to change your name, or if your name or date of birth is incorrect in either the APS or BCBSNM system.

Employees and Their Eligible Family Members - Employees covered under the APS Plan are responsible for completing and submitting signed enrollment/change forms to the APS Employee Benefits Department via Winocular. Also contact the Employee Benefits Department if a family Member's name or date of birth is incorrect in either the APS or BCBSNM system.

COBRA Continuation Members - **If you are covered under the COBRA continuation policy, contact the APS Employee Benefits Department to make any changes to your contact information, to add a newly eligible dependent, or to drop your COBRA coverage.**

COVERAGE TERMINATION

Unless stated otherwise, if you do not elect or do not qualify for continuation coverage (see "How to Continue Coverage"), coverage ends at the end of the month following the earliest of the date:

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of APS Employee Benefits Enrollment Guide.
- When the **premium payment** cannot be withheld from an employee's paycheck, or when premium payment is not received from a COBRA participant or when premium payment is not received from an employee who is on an approved leave of absence and has elected to continue medical plan coverage while on leave. (Coverage may be suspended if premium is not paid when due.) If premium is not received within 30 days after the due date, the Member(s) will be terminated at the end of the month in which payment was last made. Any claims received and paid by the medical plan during the 30-day grace period will become the responsibility of the Member and will be billed to that person.
- When the Member begins a **leave of absence** or enters the **armed forces** for **more than 30 days** or as provided by law. (See "Leave of Absence or Military Service.") Refer to the APS Employee Benefits Enrollment Guide for additional information.
- When the **Member materially fails to abide by the rules,** policies, or procedures of this Plan or fraudulently provides or materially misrepresents information affecting coverage. If a Member knowingly gave false material information in connection with the eligibility or enrollment of the Subscriber or any of his/her Eligible Family Members, **Albuquerque Public Schools** may terminate the coverage of the Subscriber and his/her Eligible Family Members retroactively to the date of initial enrollment. The Subscriber is liable for any benefit payments made as a result of such improper actions.
- When the Subscriber **dies**. (Surviving Eligible Family Members remain covered through the last day of the calendar month in which the Subscriber died.)
- If this Plan is primary over **Medicare** due to federal laws and regulations, when the Medicare-eligible Member *chooses* Medicare as his/her primary coverage. (See "Medicare-Eligible Members" for information on coverage options for Members who are entitled to Medicare.)
- When the Member acts in a **disruptive** manner that prevents the orderly business operation of any network Provider or dishonestly attempts to gain a financial or material advantage.
- When **group coverage is discontinued by APS** for the entire group or for the employee's enrollment classification.

- When **Albuquerque Public Schools** gives BCBSNM or BCBSNM gives **Albuquerque Public Schools advance written notice of plan termination as outlined in the Professional Service Agreement (the contract between APS and BCBSNM).**

Additional Family Member Termination Reasons

In addition, coverage will end for any family member on the earliest of the above dates or the earliest of the following dates:

- when premium payment is not made as shown above;
- at the end of the month when a child **no longer qualifies as an Eligible Child** under the Plan (e.g., a child is removed from placement in the home or reaches the Eligible Child age limit);
- at the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse;
- at the end of the month when the Subscriber completes an APS Enrollment/Change Form to end coverage for a covered family member(s), according to the rules of your Plan as established by APS.
- at the end of the month following the dissolution of a Domestic Partnership.

If a family member is being removed from coverage because of losing his/her eligibility under the Plan (for reasons other than reaching the Eligible Child age limit), the enrollment/change form must be received by the APS Employee Benefits Department **within 60 days** following the effective date of the change. In these cases, the Member will be removed from coverage as of the end of the month following the change in his/her eligibility status and payroll deductions will be properly adjusted, if necessary. BCBSNM and the Providers of care may recover benefits erroneously paid on behalf of the removed Member.

Voluntary Termination of Coverage

To remove a family member from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, the employee must submit a completed enrollment/change form to the APS Employee Benefits Department. *Voluntary termination is only allowed during the annual open enrollment period (for an effective date of January 1st of the next Calendar Year) and to employees who are paying for their benefits on an after-tax basis* (most APS employees elect to pay for their benefits on a pre-tax basis). Coverage will end on the last day of the month following receipt by the Employee Benefits Department of the enrollment/change form. Voluntarily terminated employees and/or family members are not eligible for continuation of coverage (COBRA).

Voluntarily terminated employees and/or family members may re-enroll during the next open enrollment period or as provided under "Special Enrollment".

Refer to the APS Employee Benefits Enrollment Guide for additional information regarding when coverage ends under this plan.

Termination and Continuation of Coverage

See "How to Continue Coverage" for more information.

Leave of Absence or Military Service

Coverage will end for a Subscriber and his/her Eligible Family Members at the end of the month during which the leave began. During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Refer to the APS Employee Benefits Enrollment Guide or contact the APS Employee Benefits Department for information.

HOW TO CONTINUE COVERAGE

If you lose coverage under this Plan, you may be able to continue coverage for a limited period of time. **Note:** There is no Special Enrollment under these provisions. You must enroll timely to qualify for continued coverage.

Continuation Coverage

APS is subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA) or state law (six-month continuation). Employees and their covered family members (including Domestic Partners) who lose eligibility under this Group Health Care Plan may be able to continue as Members, without a health statement, for a limited period of time by purchasing the continuation coverage described below. You must pay premiums from the date of loss of group coverage.

You are not eligible to enroll for continuation coverage if:

- APS stops offering this coverage to its employees, *or*
- you do not elect continuation coverage in a timely fashion.

In addition, if you elect state continuation coverage, you may not later enroll in federal continuation coverage. Refer to *Appendix A: Continuation Coverage Rights under COBRA* or contact the APS Employee Benefits Department for details about enrolling in continuation coverage.

Continuation Benefits

Continuation coverage is identical to the coverage a similarly situated regular Member has. If the coverage for regular Members changes, your continuation coverage will reflect the same change. For example, if the Plan's Deductible or other cost-sharing amounts change for regular Members, yours will change by the same amount.

Federal Continuation (COBRA)

Unless approved in writing by the APS Employee Benefits Department or BCBSNM, the following persons may not enroll in this continued coverage option:

- one who **voluntarily** terminated coverage while still eligible (*Involuntary termination* includes loss of coverage under the following situations only: legal separation, divorce, loss of Eligible Child eligibility status, death of the Subscriber, termination of employment, reduction in hours, or termination of employer contributions. Any other reason is considered voluntary.)
- a covered family member who was removed from coverage by the Subscriber while the family member was still eligible
- any Member whose APS or BCBSNM health care coverage was terminated for good cause

Continuation coverage under federal law ends on the **earliest** of the following dates or any of the applicable dates listed under “Coverage Termination” earlier in this section:

- when APS discontinues offering this Plan to employees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.)
- when the continuation period expires (If this employer's Plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

State Continuation Coverage

A Subscriber and his/her covered family members may continue Plan coverage for six months after losing coverage for any reason other than nonpayment of premium or termination of the entire group, if your group is eligible for such coverage. (See your Benefits Administrator for more information.) BCBSNM must receive the application for state continuation coverage **within 31 days** after group coverage is lost. (A health statement is not required.)

State continuation coverage ends on the **earliest** of the following dates or on the applicable dates listed under “Coverage Termination” earlier in this section:

- when the employer discontinues offering this Plan to employees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.)
- when the continuation period expires (If this employer's Plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

If you are entitled to both Parts A and B of Medicare, your state continuation coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. (The options for Members under age 65 are limited.) Call a Customer Service Advocate for more information.

Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA administrator. Subscribers under state continuation coverage pay premiums to BCBSNM. Contact the APS Employee Benefits Department for a COBRA Enrollment Form for coverage, and for details.

USERRA Continuation Coverage

Employees and their covered family members who lose group coverage because the employee is absent from work due to military service may be able to continue coverage for **up to 24 months** after the absence begins. Contact the APS Employee Benefits Department for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

CONVERSION TO INDIVIDUAL COVERAGE

Members of the Group insured have the right to continue coverage for a period of six months and thereafter through a conversion policy upon termination of membership or employment with the Group insured. Covered family members of an employee or Member of the Group insured have the right to continue coverage through a converted or separate policy upon the death of the Member or employee of the Group insured or upon divorce, annulment or dissolution of marriage or legal separation of the spouse from the Member or employee of the Group insured.

Where continuation of coverage or conversion is made in the name of the spouse of the named insured or the spouse of the Group insured or Member of the Group insured, such coverage may, at the option of the spouse, include coverage for dependent children for whom the spouse has responsibility for care and support.

The right to a continuation of coverage or conversion shall not exist with respect to any Member or employee of the Group insured or any covered family member in the event the coverage terminates for nonpayment of premium, non-renewal of the policy or the expiration of the term for which the policy is issued. With respect to any Member or employee of the Group insured or any covered family member who is eligible for Medicare or any other similar federal or state health insurance program, the right to a continuation of coverage or conversion shall be limited to coverage under a Medicare supplement insurance policy as defined by the rules and regulations adopted by the superintendent.

Coverage continued through the issuance of a converted or separate policy shall be provided at a reasonable, nondiscriminatory rate to the insured and shall consist of a form of coverage then being offered by BCBSNM as a conversion policy in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the policy from which conversion is exercised. Continued and converted coverages shall contain renewal provisions that are not less favorable to the insured than those contained in the policy from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a Medicare supplement insurance policy, as defined by the rules and regulations adopted by the superintendent, after the attainment of the age of eligibility for Medicare or any other similar federal or state health insurance program.

At the time of inception of coverage, BCBSNM shall furnish to each covered family member who is eighteen years of age or over and to each employee or Member of the Group insured a statement setting forth in summary form the continuation of coverage and conversion provisions of the policy.

BCBSNM shall notify in writing each employee or Member, upon that employee's or Member's termination of employment or membership with the Group insured, or the continuation and conversion provisions of the policy. The employer may give the written notice specified herein. The employer should notify BCBSNM of the employee's or Member's change of status and last known address. Under no circumstances shall the employer have any civil liability under the conversion provisions of New Mexico law.

The eligible employee or Member of the Group insured or covered family member exercising the continuation or conversion right shall notify the employer or BCBSNM and make payment of the applicable premium within thirty days following the date of the notification given BCBSNM. There shall be no lapse of coverage during the period in which conversion is available;

Coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation or conversion is exercised;

Benefits otherwise payable under a converted or separate policy may be reduced so they are not, during the first policy year of the converted or separate policy, in excess of those that would have been payable under the policy from which conversion is exercised. Benefits, if any otherwise payable under a converted or separate policy are not payable for a loss claimed under the policy from which conversion is exercised; and

Any probationary or waiting period set forth in the converted or separate policy is deemed to commence on the effective date of the applicant's coverage under the original policy.

SECTION 3: HOW YOUR PLAN WORKS

BENEFIT CHOICES

BlueNet EPO is a health care plan that provides benefits under agreement with an exclusive network of Preferred Providers. When you need non-Emergency health care that is covered under this Plan, **you must choose a Primary Preferred Provider from the Blue Cross and Blue Shield "Preferred Provider Organization (PPO)" network in order to receive benefits.**

At A Glance

EPO Provider Services

- You must choose a Primary Preferred Provider (PPP) and use Preferred Providers, except in an Emergency and specified situations described under "Benefit Level Exceptions" later in this Section.
- You pay an annual Deductible and a percentage of Covered Charges (Coinsurance) after the Deductible is met or, in some cases a fixed-dollar amount (Copayment) for a Covered Service.
- You have an annual Out-of-Pocket Limit.
- The Preferred Provider is responsible for filing Claims for you directly to the local Blue Cross and Blue Shield Plan.
- The Preferred Provider will not bill you for amounts above the Covered Charge, which may be less than the billed charge. The "Covered Charge" is the amount that BCBSNM determines is fair and reasonable allowance for a particular Covered Service. After your share of a Covered Charge (e.g., Deductible, Coinsurance, Copayment) has been calculated, BCBSNM pays the remaining amount of the Covered Charge, up to maximum benefit limits, if any.
- Preferred Providers that contract **directly** with BCBSNM are responsible for requesting all necessary Prior Authorizations for you. (Providers that contract with another BCBS Plan may call for Prior Authorization on your behalf, but you will be responsible for making sure that Prior Authorization is obtained when required. If you do not obtain Prior Authorization, benefits may be denied.)

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

Preferred Providers are Health Care Professionals and facilities that have Contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as "Preferred" Providers. These Providers have agreed to provide health care for **EPO** Plan Members and accept the Plan's payment for a Covered Service plus the Members share of the Covered Charge (i.e., Deductible, Coinsurance, and/or Copayment) as payment in full.

Nonpreferred Providers are Providers that have not Contracted with BCBSNM, either directly or indirectly, to be part of the "Preferred" Provider network. (These Providers may have "Participating" Provider agreements, but are **not** considered Preferred. See *Section 8: Claims Payments and Appeals* for more information.) **Unless listed as an exception under "Benefit Level Exceptions," services of Nonpreferred Providers are not covered.**

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.)

Unless listed under "Benefit Level Exceptions," benefits are not available for non-Emergency services received from a Nonpreferred Provider.

Covered Charges
*For Covered Charges related to Claims from Providers that contract directly with BCBSNM, see "Covered Charges" in *Section 8: Claims Payments and Appeals.*
*For Covered Charges related to Claims from Out-of-Network Providers, see "Benefit Level Exceptions" later in this *Section 3: How Your Plan Works.*
*For Covered Charges related to Claims from Providers outside New Mexico, see "BlueCard" in *Section 8: Claims Payments and Appeals.*

PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

When you need medical care, there are a variety of ways you can choose a Primary Preferred Provider (PPP) or other Preferred Provider in your area. You can also access Mental Disorder Providers (including those specializing in Chemical Dependency) and Participating Pharmacies. **Note:** Only those Providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology and Pediatrics are considered Primary Preferred Providers (PPPs). See "Cost-Sharing Features," later in this section for details.

Whichever method you choose, the Provider directory gives each Provider's specialty, the language spoken in the office, the office hours, and other information such as whether the office is handicapped accessible. (To find this information on the website directory, click on the Doctor's name once you have found one you want to know more about.) The website directory also gives you a map to the Provider's office.

Although Provider directories are current as of the date shown at the bottom of each page of a printed directory or as of the date an Internet site was last updated, the network and/or a particular Provider's status can change without notice. To verify a Provider's current status, request a current directory, request a paper copy of a directory (free of charge), or if you have any questions about the directory, contact a BCBSNM Customer Service Advocate. It is also a good idea to speak with a Provider's office staff directly to verify whether or not they belong to the BCBS Preferred Provider network before making an appointment.

Web-Based BCBSNM Provider Finder

To find a Preferred Provider in New Mexico or along the border of neighboring states, please visit the *Provider Finder* section of the BCBSNM website for a list of Network Providers: www.bcbsnm.com

The website is the most up-to-date resource for finding Providers and also has an Internet link to the national Blue Cross and Blue Shield Association website for services outside New Mexico. Website directories also include maps and directions to Provider locations.

Paper Provider Network Directory

If you want a paper copy of a *BCBSNM Preferred Provider Network Directory*, you may request one from BCBSNM Customer Service and it will be mailed to you free of charge. You may also call BCBSNM and request a paper copy of a BCBS Provider directory from another state.

Although Provider directories are current as of the date shown at the bottom of each page of a printed directory or as of the date an Internet site was last updated, the network and/or a particular Provider's status can change without notice. To verify a Provider's current status, request a paper copy of a directory (free of charge), or if you have any questions about the directory, contact a BCBSNM Customer Service Advocate. It is also a good idea to speak with a Provider's office staff directly to verify whether or not they belong to the BCBS Preferred Provider network before making an appointment.

Paper Provider Network Directory

If you want a paper copy of a *BCBSNM Preferred Provider Network Directory*, you may request one from BCBSNM Customer Service and it will be mailed to you free of charge. You may also call BCBSNM and request a paper copy of a BCBS Provider directory from another state.

Providers Outside New Mexico

Out-of-state Providers that contract with their local Blue Cross and/or Blue Shield Plan and international Providers that contract with the Blue Cross and Blue Shield Association as **Preferred Providers** are also eligible for the

"Preferred Provider" level of benefits for Covered Services, including fixed-dollar Copayment amounts listed on the *Plan Highlights.* **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 (unless listed under **"Benefit Level Exceptions,"** later in this section).

You have a number of ways to locate a Preferred Provider in the United States or around the world:

BCBSNM Website

If you have an Internet connection, go to the BCBSNM website at www.bcbsnm.com, click on "Find Care" and then select the line entitled "Providers located outside New Mexico." You will then be linked to the Blue Cross Blue Shield Association's BlueCard Doctor and Hospital Finder.

BCBSNM website: www.bcbsnm.com

National Website

Visit the Blue Cross and Blue Shield Association website at www.bcbs.com and click on "Members" then select "Find a Doctor" Follow the instructions.

Blue Cross and Blue Shield Association website:

www.bcbs.com (or www.bluecares.com)

National Phone Number

Call BlueCard Access at the phone number below for the names and addresses of doctors and Hospitals in the area where you or an Eligible Family Member need care. When you call, a BlueCard representative will give you the name and telephone number of a local Provider (you will be asked for the zip code in the area of your search) 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. Call:

1-800-810-BLUE (2583)

International Assistance

Call the Service Center at one of the phone numbers **below**, 24 hours a day, 7 days a week, for information on doctors, Hospitals, and other Health Care Professionals or to receive medical assistance services around the world. An assistance coordinator, in conjunction with a medical professional, will help arrange a doctor's appointment or hospitalization, if necessary. If you need to be hospitalized, call BCBSNM for Prior Authorization. You can find the Prior Authorization phone number on your ID Card. **Note:** The phone number for Prior Authorization is different from the following phone numbers, which are strictly for locating a Preferred Provider while outside the United States:

1-800-810-BLUE (2583) or call collect: 1-804-673-1177

CALENDAR YEAR

A Calendar Year is a period of one year which begins on January 1 and ends on December 31 of the same year. The initial Calendar Year is from a Members Effective Date of Coverage through December 31 of the same year, which may be less than 12 months.

BENEFIT LIMITS

There is no general lifetime maximum benefit under this Plan. However, certain services have separate benefit limits per Admission or per Calendar Year. (See the *Plan Highlights* for details.)

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.

COST-SHARING FEATURES

For some services, you will pay only a fixed-dollar amount Copayment for covered charges. In other cases, you will have to meet a Deductible and pay a percentage of the covered charge (Preferred Providers will not bill you for amounts in excess of the covered charge). When you receive a number of services during a single visit or procedure, you may have to pay both a Copayment and a Deductible (if applicable) plus a percentage of the covered charges that are not included in the copayment. Refer to your *Plan Highlights* for details.

YOUR DEDUCTIBLE

Your Deductible is the amount of Covered Charges that you must pay in a Calendar Year before this Plan begins to pay its share of the Covered Charges you incur during the same Calendar Year. If the Deductible amount remains the same during the Calendar Year, you pay it only once each Calendar Year, and it applies to Covered Services subject to the Deductible and Coinsurance you receive during that Calendar Year.

Individual Deductible

The individual Deductible is listed on the *Summary of Benefits.* Once a Member's Deductible payments for Covered Services reach the individual Deductible amount, this Plan will begin paying its share of that Member's Covered Charges for the rest of the Calendar Year.

Two-Person Deductible

The two-person deductible is listed on the *Summary of Benefits.* This deductible applies when two individuals are enrolled on the plan. The Two-Person Deductible must be met before the plan will begin paying its share of those two member's covered charges for the rest of the Calendar Year.

Family Deductible

An entire family meets the applicable annual Deductible when the total Deductible amount for all family members reaches the amount specified on your *Plan Highlights.* (The Deductible amounts for three or more family members are combined to satisfy the family Deductible.) **Note:** If a member's Individual Deductible is met, no more charges incurred by that member may be used to satisfy the applicable Family Deductible.

What Is Not Subject to the Deductible

The following are **not applied** to the annual Deductible:

- services with Copayments
- CAC (coronary artery calcification) tests
- the following services when received from Preferred Providers: preventive care, diagnostic tests,(excluding MRIs, PET scans, and CT scans performed at a hospital), hearing aids and ear molds for members under the age 21, Emergency room and Urgent Care services, and Physical, Occupational and Speech Therapy

Admissions Spanning Two Calendar Years

If a Deductible has been met while you are an inpatient and the Admission continues into a new Calendar Year, no additional Deductible is applied to that Admission's Covered Services. However, all other services received during the new Calendar Year are subject to the Deductibles for the new Calendar Year.

Timely Filing Reminder

Most benefits are payable only after BCBSNM's records show that the applicable Deductible has been met. Preferred Providers and Providers that have "Participating-only" Provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time (usually 180 days). If you file your own claims for Emergency or Urgent Care 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 *Section 8: Claim Payments and Appeals* for details.

COPAYMENTS

When you visit a Preferred Provider in his/her office, the office visit charge is subject to the PPP office visit Copayment described below. Other services received during the visit, services of other Preferred Providers are subject to the Deductible, Coinsurance, and Out-of-Pocket Limit provisions described below.

Office Visit Copayment

When you receive **office services** from a Preferred Provider, you pay only a fixed-dollar amount (or copayment), for his/her covered **office visit charge**. The Copayments for "Primary Preferred Provider" (PPP) and PPO Specialist office visits are listed on the *Plan Highlights.* However, all other services received during the office visit (such as chemotherapy) will be subject to regular Deductible and/or Coinsurance requirements and/or to an additional Copayment as listed on the *Plan Highlights.*

Primary Preferred Provider (PPP) is 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.

Preferred (PPO) Specialist is a practitioner of the healing arts who is in the Preferred Provider Network - but does not belong to one of the specialties defined above as being for a "Primary Preferred Provider" (or "PPP"). A PPO Specialist does not include Hospitals or other treatment Facilities, Urgent Care Facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary Health Care Providers.

COINSURANCE

For some Covered Services, you must pay a percentage of covered charges (Coinsurance) after you have met your annual Deductible. After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any.

OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit is the maximum amount of Deductible, Coinsurance, and Copayments that you pay for most Covered Services in a Calendar Year. After the Out-of-Pocket Limit is reached, this Plan pays 100 percent of most of your Covered Charges for the rest of the Calendar Year, not to exceed any benefit limits.

Individual Limits

Once your Coinsurance amounts for Preferred Provider services in a Calendar Year reaches the individual Preferred Provider amount indicated on the *Plan Highlights,* this Plan pays 100 percent of most of your covered Preferred Provider charges for the rest of the Calendar Year.

Family Limits

An entire family meets the Out-of-Pocket Limit during a Calendar Year when the total Coinsurance for all family members reaches the amount specified in the *Plan Highlights*. (When a member meets the Individual Out-of-Pocket Limit, no more charges incurred by that member may be used to satisfy the applicable Family Out-of-Pocket Limit.)

What Is Not Included in the Out-of-Pocket 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, if applicable)
- noncovered expenses (including services in excess of annual or lifetime day/visit limits)
- drug plan Copayments (refer to the APS prescription drug Summary of Benefits for the prescription drug plan Out-of-Pocket Limit)

See the Plan Highlights for your Deductible amounts, Coinsurance percentages and Out-of-Pocket Limit amounts.

CHANGES TO THE COST-SHARING AMOUNTS

Although it is unlikely, Copayments, Coinsurance percentage amounts, Deductibles, and Out-of-Pocket Limits may change during a Calendar Year. If changes are made, the change applies only to services received after the change goes into effect (for inpatient services, benefits are determined based on the date you are admitted to the Facility). You will be notified by the APS Employee Benefits Department if changes are made to this Plan. Although it is unlikely, if APS increases the Deductible or Out-of-Pocket Limit amounts during a Calendar Year, the new amounts must be met during the same Calendar Year. For example, if you have met your Deductible and APS 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.

BENEFIT LEVEL EXCEPTIONS

Benefits will be provided as indicated on the *Plan Highlights*, except as listed below.

Emergency Care

If you visit a Nonpreferred (Non-Contracted) Provider for Emergency care, including Emergency room services, you will receive benefits for the initial treatment at the Preferred Provider (Office/Urgent Care Facility services are not considered "Emergency Care" for purposes of this provision.) Non-Emergency services provided in an emergency room for treatment of Mental Disorders or Chemical Dependency will be paid the same as Emergency Care services.

For follow-up care (which is no longer considered Emergency Care) and for all other non-Emergency Care, you will receive no benefit for the services of a Nonpreferred provider, except as specified below. (See "Emergency and Urgent Care" In Section 5: *Covered Services* for more information.

Transition of Care

This provision applies to both Continuity of Care and Transition of Care. If your Health Care Provider leaves the BCBSNM 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 Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the Provider you have been seeing 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 out-of-network Providers.) An ongoing course of treatment will include, but is not limited to: (1) Treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) Treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, Radiation Therapy or post-operative visits; (3) The second or third trimester of pregnancy, through the postpartum period; or (4) An ongoing course of treatment for a health condition for which a treating Physician or Health Care Provider attests that discontinuing care by that Physician or Health Care Provider would worsen the condition or interfere with anticipated outcomes. 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. Call the BCBSNM Customer Service department for details.

Members who extend coverage under an extension of benefits due to disability are not eligible to request Transition of Care for services of an out-of-network Provider. Services of an out-of-network Provider are **not** covered at the in-network level (if any) in such instances of extended coverage.

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). In New Mexico, ambulance Providers fall into this category. These Provider types are referred to as "unsolicited Providers." Unsolicited Providers vary 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, except as noted in the Federal No Surprises Act Amendment to this Benefit Booklet, the unsolicited Provider may still bill you for amounts that are in excess of covered charges. Except as noted in the Federal No Surprises Act Amendment to this Benefit Booklet, you will be responsible for these amounts, in addition to your Deductible and Coinsurance.

Ancillary Provider

Once you have obtained Prior Authorization 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, except as noted in the Federal No Surprises Act Amendment to this Benefit Booklet.

Note: Except as described above, the Preferred Provider benefit level will not apply to non-Emergency services when received from a Nonpreferred Provider.

SECTION 4: UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. Requirements for Medical Necessity may vary based upon your Plan benefits. Medical Necessity reviews may occur when a Provider requests an authorization prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. However, some services may require a Prior Authorization before the start of services.

Types of Utilization Management:

- Prior Authorization
- Predetermination
- Post-Service Medical Necessity Reviews

Refer to the definition of Medically Necessary/Medical Necessity in ***Section 10: Definitions*** in this Benefit Booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

PRIOR AUTHORIZATION

Prior Authorizations are a requirement that you, your Provider, or an authorized representative, must obtain authorization from BCBSNM before you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

- services must be covered and Medically Necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

Prior Authorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. Prior Authorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits. Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this plan, and services that are not Medically Necessary will be denied.

Medically Necessary/Medical Necessity is defined as 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 Disorder condition, illness, injury, or disease.

Please note:

Prior Authorization is a requirement that you or your Provider must obtain authorization from BCBSNM before you are admitted as an inpatient and before you receive certain types of services.

Even when this plan is not your primary coverage, these Prior Authorization procedures must be followed. Failure to do so may result in a denial of benefits.

Most Prior Authorization requests will be evaluated and you and/or the Provider notified of BCBSNM's decision within 15 days of receiving the request (within 24 hours for Urgent Care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see ***Section 8: Claims Payments and Appeals***) and "If Your Prior Authorization Request is Denied" later in this section).

Retroactive approvals will not be given, except for Emergency and Maternity-related Admissions, and you may be responsible for the charges if Prior Authorization is not obtained before the service is received.

HOW THE PRIOR AUTHORIZATION PROCEDURE WORKS

When you or your Provider call, BCBSNM's Health Services representative will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay (if you are being admitted). The Health Services representative will evaluate the information and notify the requesting Provider (usually at the time of the call) if Prior Authorization of benefits for the proposed hospitalization or other services is approved. If Prior Authorization is denied for the Admission or other services, you may appeal the decision as explained in ***Section 8: Claims Payments and Appeals***.

BCBSNM PREFERRED PROVIDERS

If the attending Physician is a Preferred Provider that contracts directly with BCBSNM, obtaining Prior Authorization is not your responsibility — it is the Provider's. Preferred Providers must obtain Prior Authorization from BCBSNM (or from the Behavioral Health Unit (BHU), when applicable) in the following circumstances:

- when recommending any non-Emergency Admission, re-Admission, or transfer
- when a covered newborn stays in the Hospital longer than the mother
- before providing or recommending a service listed under "Other Prior Authorizations," later in this section

Note: Providers that contract with other Blue Cross and Blue Shield plans are not familiar with the Prior Authorization 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 Prior Authorization requirements. In this situation, you must contact BCBSNM to obtain Prior Authorization.

NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

If any Provider outside New Mexico (except for those contracting as Preferred Providers directly with BCBSNM) or any Nonpreferred Provider recommends an Admission or a service that requires Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, your benefits for Covered Services may be denied for some services or you may be entirely responsible for the charges. The Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is called.

INPATIENT PRIOR AUTHORIZATION

Prior Authorization is required for all Admissions before you are admitted to the Hospital or other inpatient treatment Facility (e.g., Skilled Nursing Facility, Residential Treatment Center, physical rehabilitation Facility, long-term acute care (LTAC). If you are receiving services at an Out-of-Network Facility (or from an In-Network Facility outside New Mexico) and you do not obtain authorization within the time limits indicated in the table below, benefits for covered Facility services will be denied as explained under *"Not Obtaining Inpatient Prior Authorization"* below.

Type of inpatient Admission, re-Admission, or transfer:	When to obtain inpatient Admission Prior Authorization:
Non-Emergency	Before the patient is admitted.
Emergency, non-Maternity; or Emergency Room services to treat Mental Disorders or Chemical Dependency	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 is not covered)	Before the mother's Maternity due date**,** soon after pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than 48 hours for a routine delivery or greater than 96 hours for a C-section delivery.
Extended stay, newborn (an eligible newborn stays in the Hospital longer than the mother)	Before the newborn's mother is discharged.

NOT OBTAINING INPATIENT PRIOR AUTHORIZATION

If you or your Provider do not receive Prior Authorization for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid 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 will be denied.*
The Admission was for an item listed under "Other Prior Authorizations," (e.g., elective Admissions).	Benefits for the Facility and all related services may be denied.*
The Admission was for any other Covered Service but hospitalization was not Medically Necessary.	Benefits may be denied for room, board, and other charges that are not Medically Necessary.*
The Admission was for a Medically Necessary Covered Service.	Benefits for the Facility's Covered Services will be reduced by $300*

*The Admission review penalty of $300 and charges for noncovered and denied services are **not applied** to any Deductible or Out-of-Pocket Limit. You are responsible for paying this amount for out-of-network services.

Inpatient Prior Authorization 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 AUTHORIZATIONS

In addition to Prior Authorization review for all non-Emergency Inpatient Services, Prior Authorization is required for certain other services listed below. Most Prior Authorizations may be requested over the telephone. If a *written* request is needed, have your Provider call a Health Services representative for instructions for filing a written request for Prior Authorization. (See *"Inpatient Prior Authorization"* (or similar heading) for further information regarding inpatient Prior Authorization requirements.)

If Prior Authorization is not obtained for the following services and any related services, the service will be reviewed for Medical Necessity and subject to one of the following actions in the chart below:

No Prior Authorization Received:	Claim Disposition: Preferred	Claim Disposition: Nonpreferred
Service is Medically Necessary	Claim is paid based on Members benefit plan	Claim is paid based on Members benefit plan
Service is not Medically Necessary	Claim is denied; Member is held harmless	Claim is denied

Services that require Prior Authorization:

- Non-Emergency Air Ambulance transportation
- All inpatient Hospital Admissions
- The following Outpatient Services and procedures:
  - Home Health Care
  - Home infusion therapy (HIT), excluding antibiotics
  - Outpatient infusion drugs
  - Home Hospice services
  - Transitional care benefits
  - Certain injections, including but not limited to intravenous immunoglobulin (IVIG)
  - Outpatient Surgery performed at a Hospital or Ambulatory Surgical Facility for out-of-network services only
  - Transplant Evaluations and Transplants

— **Ear, Nose and Throat (ENT):**
  - Bone Conduction Hearing Aids
  - Cochlear Implant
  - Nasal and Sinus Surgery

— **Gastroenterology (Stomach):**
  - Gastric Electrical Stimulation (GES)

— **Neurological:**
  - Deep Brain Stimulation
  - Sacral Nerve Neuromodulation/Stimulation
  - Vagus Nerve Stimulation (VNS)

— **Orthopedic Musculoskeletal:**
  - Artificial Intervertebral Disc
  - Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions
  - Femoroacetabular Impingement (FAI) Syndrome
  - Lumbar Spinal Fusion
  - Meniscal Allografts and Other Meniscal Implants
  - Orthopedic Applications of Stem-Cell Therapy

— **Specialty Pharmacy:**
  - Medical Benefit Specialty Drugs (Specialty Drugs administered by your Provider)

— **Surgical Procedures:**
  - Orthognathic Surgery
  - Mastopexy
  - Reduction Mammoplasty; Breast Reduction

— **Wound Care:**
  - Hyperbaric Oxygen (HBO2) Therapy-Systemic

For specific details about the Prior Authorization requirement for the above referenced Outpatient Services, please call Customer Service at the number on the back of your Identification Card. BCBSNM reserves the right to no longer require Prior Authorization during the Calendar Year. Updates to the list of services requiring Prior Authorization may be confirmed by calling Customer Service.

BCBSNM will send a letter to you, your Physician and the Hospital or Facility with a determination of your Prior Authorization review no later than seven (7) business days after BCBSNM receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters will not be received prior to your scheduled date of service or procedure.

All services, including those for which Prior Authorization is required, must meet the standards of Medical Necessity criteria described in ***Section 5: Covered Services***, "Medically Necessary Services,". Excluded services will not be covered, if excluded, for any reason. Some services requiring Prior Authorization may not be approved for payment (for example, due to being Experimental, Investigational or Unproven, or not Medically Necessary). Services requiring Prior Authorization are subject to review and change by BCBSNM.

The Prior Authorization requirements noted above do not apply to mandated benefits, unless permitted by law and stated in the provisions of a specific mandated benefit. Gynecological or obstetrical ultrasounds do not require Prior Authorization. The Medical Necessity requirements noted above do not apply to mandated benefits, unless permitted by law.

It is strongly recommended that you request a Predetermination for benefits for high-cost services in order to reduce the likelihood of benefits being denied after charges are incurred. See "Predetermination" later in this section for further information.

PRIOR AUTHORIZATION OF MENTAL DISORDER/CHEMICAL DEPENDENCY SERVICES

You must obtain Prior Authorization for all inpatient Mental Disorders and Chemical Dependency services from the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID Card. Prior Authorization is also required for the following Outpatient Services for treatment of Mental Disorder and/or Chemical Dependency:

- psychological testing
- neuropsychological testing
- Intensive Outpatient Program (IOP) treatment
- electroconvulsive therapy (ECT)
- repetitive transcranial magnetic stimulation
- Applied Behavior Analysis (ABA) therapies

Prior Authorization is not required for Group, individual, or family therapy outpatient office visits to a Physician or other Professional Provider licensed to perform Covered Services under this health plan.

For services needing Prior Authorization, you or your Health Care Provider should call the BHU before you schedule treatment. **NOTE:** Your Provider may be asked to submit clinical information in order to obtain Prior Authorization for the services you are planning to receive. Services may be authorized or may be denied based on the clinical information received. (*Clinical information* is information based on actual observation and treatment of a particular patient.)

If you or your Provider do not call for Prior Authorization of non-Emergency Inpatient Services, benefits for covered, Medically Necessary inpatient Facility care may be denied. If Inpatient Services received without Prior Authorization are determined to be not Medically Necessary or not eligible for coverage under your plan for any other reason, the Admission and all related services will be denied. In such cases, you may be responsible for all charges.

If Prior Authorization is not obtained before you receive psychological testing, IOP treatment, neuropsychological testing, electroconvulsive therapy repetitive transcranial magnetic stimulation or Applied Behavior Analysis (ABA) therapies, your Claims may be denied if it is not Medically Necessary. In such cases, you may be responsible for all charges. Therefore, you should make sure that you (or your Provider) have obtained Prior Authorization for Outpatient Services before you start treatment.

Use the chart below to determine the appropriate contact for your situation.

Summary of Contact Information for Prior Authorization, Customer Service, Claim Submission and Appeal (or Reconsideration) Processes for Medical/Surgical and Mental Disorders/Chemical Dependency Services:			
Process:	**Type of Service:**	**Phone:**	**Send to:**
Request Prior Authorization	Medical/Surgical	1-800-325-8334	BCBSNM P.O. Box 660058 Dallas, TX 75266-0058
	Mental Disorder/Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 660058 Dallas, TX 75266-0058
Customer Service Inquiry	Medical/Surgical	1-888-371-1928	BCBSNM P.O. Box 660058 Dallas, TX 75266-0058
	Mental Disorder/Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 660058 Dallas, TX 75266-0058
Submit Claim (post-service)	Medical/Surgical		BCBSNM P.O. Box 660058 Dallas, TX 75266-0058
	Mental Disorder/Chemical Dependency		BH Unit P.O. Box 660058 Dallas, TX 75266-0058
Request appeal of Claim or Prior Authorization decision	Medical/Surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 660058 Dallas, TX 75266-0058
	Mental Disorder/Chemical Dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 660058 Dallas, TX 75266-0058
Grievance Assistance - Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/Surgical; Mental Disorder/Chemical Dependency	1-855-427-5674	Office of Superintendent of Insurance P.O. Box 1689 Santa Fe, NM 87504-1689

IF YOUR PRIOR AUTHORIZATION REQUEST IS DENIED

BCBSNM has established written procedures for reviewing and resolving your concerns. There are two different procedures depending upon the type of issue involved - pre-service or post-service. This is a summary of the procedures that apply to Prior Authorization requests ("pre-service Claims"). For appeals involving post-service Claims payments or denials, see ***Section 8: Claims Payment and Appeals***.

If you are dissatisfied at any time during the process described below, you may file an appeal. You may designate a representative to act for you in the review and appeal procedures. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. If you make an inquiry or request an appeal under the following procedures, you will not be subject to retaliatory action by BCBSNM.

If you have an inquiry or a concern about any Prior Authorization request, call your Customer Service Advocate for assistance. Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service Advocate will assist you.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Benefit Booklet.

Upon completion of the preadmission or emergency Admission review, BCBSNM will send you a letter confirming that you or your representative called BCBSNM. A letter authorizing a length of service or length of stay will be sent to you, your Physician, Behavioral Health Practitioner and/or the Hospital or Facility.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in Appendix B: Notice—Inquiries/Complaints and Internal/External Appeals for Self-Funded Plans section of this Benefit Booklet.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the plan for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an ongoing course of treatment, the plan will make a determination on the request as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

PREDETERMINATION

Predetermination is an optional Medical Necessity review by BCBSNM of a medical procedure, treatment or test, that has been recommended by your Physician in order to determine if it meets approved BCBSNM medical policy guidelines. A Predetermination review is not the same as Prior Authorization. Prior Authorization is a required process for the Provider to get approval from the plan before you are admitted to the Hospital or for certain types of Covered Services. A Predetermination review can help you avoid unexpected Out-of-Pocket costs by determining ahead of time if a recommended service will be covered by your health care plan. If a service requires Prior Authorization, a Predetermination review is not available.

Predetermination review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Benefit Booklet. Please coordinate with your Provider to submit a written request for Predetermination.

Below are some examples (not an exhaustive list) of some common services for which a Predetermination review is recommended:

- Certain higher cost Durable Medical Equipment;
- Surgeries that might be considered cosmetic; and
- Services and supplies that may be Experimental/Investigational under certain circumstances

General Provisions Applicable to All Predeterminations

a) No Guarantee of Payment

A Predetermination is not a guarantee of benefits or payment of benefits by BCBSNM. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Benefit Booklet. Even if the service has been approved on Predetermination, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's benefits may have change as of the date of service.

b) Request for Additional Information

The Predetermination process may require additional documentation from the Member's health care Provider. In addition to the written request for Predetermination, the health care Provider may be

required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSNM to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Member eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be available when a Prior Authorization or Predetermination was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

a) No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Benefit Booklet. Post-Service Medical Necessity Reviews do not guarantee payment of benefits by BCBSNM, for instance a Member may become ineligible as of the date of service or the Member's benefits may have changed as of the date of service.

b) Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the Member's health care Provider. In addition to the written request for Post-Service Review, the health care Provider may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSNM to make a determination of coverage pursuant to the terms and conditions of this Plan.

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this Group Health Care Plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on Covered Charges as determined by BCBSNM. **To be covered, services must be Medically Necessary or listed as a Covered Service below. If a service is not listed as a Covered Service, it will be covered as long as that service is Medically Necessary and is not specifically excluded in this Benefit Booklet.**

Certain services are covered pursuant to BCBSNM medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by BCBSNM when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and is eligible as a COVERED SERVICE or is EXPERIMENTAL/INVESTIGATIONAL, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsnm.com, or call BCBSNM Customer Service at the number listed on the back of your ID Card.

Reminder: It is to your financial advantage to receive care from Primary Preferred Providers (PPPs) and other Preferred and Participating Providers. This EPO Plan provides In-Network ONLY coverage on a Nationwide basis. This means that you must use Preferred or Participating Providers contracted with Blue Cross Blue Shield.

MEDICALLY NECESSARY SERVICES

A service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this Plan, and is determined by BCBSNM's medical director (in consultation with your Provider) to meet the following definition:

Medically Necessary is defined as 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, Mental Disorder or Chemical Dependency condition, illness, injury, or disease.

All services must be eligible for benefits as described in this section, not listed as an exclusion and/or meet all of the conditions of Medical Necessity as defined above in order to be covered.

Note: Because a Health Care 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. BCBSNM at its sole discretion will determine Medical Necessity based on the criteria above.

Prior Authorizations are a requirement that you or your Provider must obtain authorization from BCBSNM before you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

- services must be covered and Medically Necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

Prior Authorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. **Prior Authorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits.** Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this Plan, and services not Medically Necessary will be denied.

AMBULANCE SERVICES

This Plan covers Ambulance services in an Emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a non-Emergency situation, this Plan also covers Medically Necessary Ambulance transportation to a Hospital with appropriate facilities, or from one Hospital to another.

Air Ambulance

Ground Ambulance is usually the approved method of transportation. 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. To be covered, non-Emergency Air Ambulance services require **Prior Authorization** from BCBSNM.

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.

Exclusions

This Plan does **not** cover:

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair Ambulance
- services ordered only because other transportation was not available, or for your convenience

AUTISM SPECTRUM DISORDERS

This Plan covers the Habilitative and Rehabilitative treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA) with no age restrictions or age limits for the Member. Providers must be credentialed to provide such therapy. In addition, well-baby and well-child screening for diagnosing the presence of autism spectrum disorder is a Covered Service.

Treatment must be prescribed by the Members treating Physician in accordance with a treatment plan. The **treatment plan** must obtain Prior Authorization from BCBSNM to determine that the services are to be performed in accordance with such a treatment plan; if services are received but were not approved as part of the treatment plan, benefits for services will be denied.

Services not approved through Prior Authorization by BCBSNM must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services will be denied. Examples include therapy for a child who ~~i~~sn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired disorder. These services also may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Policy. Please review the **Short-Term Rehabilitation: Occupational, Physical, Speech Therapy** section of this Policy.

Services are subject to usual Member cost-sharing features such as Deductible, Coinsurance, Copayments, and Out-of-Pocket Limits - based on place of treatment and type of service, except where prohibited by state or federal law. Note: Applied Behavioral Analysis (ABA) therapies are not subject to Member cost-sharing, when received from a Network Provider. All services are subject to the *General Limitations and Exclusions* except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the Plan, including but not limited to: coordination of benefits, Participating Provider agreements, restrictions on Health Care Services, including review of Medical Necessity, case management, and other Managed Care provisions.

Regardless of the type of therapy received, Claims for services related to Autism Spectrum Disorder should be submitted to BCBSNM - **not** to the behavioral health unit.

Exclusions

This Plan does **not** cover:

- any Experimental, long-term, or maintenance treatments unless listed above
- Services that are not Medically Necessary
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have Autism Spectrum Disorder
- services in accordance with a treatment plan that has not obtained Prior Authorization from BCBSNM
- respite services or care
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch therapy
- floor time
- facilitated communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy
- hippotherapy, animal therapy, or art therapy

DENTAL-RELATED SERVICES AND ORAL SURGERY

The following services are the only Dental-Related Services and oral surgery procedures covered under this Plan. When alternative procedures or devices are available, benefits are based upon the most Cost-Effective, medically appropriate procedure or device available.

Dental and Facial Accidents

Benefits for Covered Services for the treatment of Accidental Injury to the jaw, mouth, face or to sound natural teeth are subject to the same limitations, exclusions and member cost-sharing provisions that apply to Emergency

room or Urgent Care treatment, or to other similar services when not dental-related (e.g., x-rays, medical supplies, surgical services). Injury to the teeth, mouth, jaw or face as a result of chewing, biting or malocclusion is not considered an Accidental Injury. Services or supplies provided for the treatment of an Accidental Injury resulting from an act of domestic violence or a medical condition are covered services.

Sound natural teeth are teeth that are whole or properly restored by amalgams, without impairment, periodontal or other conditions, and not in need of treatment for any reason other than the Accidental Injury. Teeth with crowns or restorations (including dental implants) are not considered sound natural teeth.

To be covered, *initial* treatment for the injury must be sought **within 72 hours** of the accident and any services required after the initial treatment must be associated with the initial accident to be covered. All covered treatments for dental trauma must be completed within 12 months of the specific traumatic injury, and all services subsequent to the initial treatment must be **preauthorized by BCBSNM.** When alternative dental or surgical procedures or Prosthetic Devices are available, the dental accident benefit allowance is based upon the least costly procedure or Prosthetic Device. (Dental prostheses may include the placement of dental implants to restore the area of trauma *only if it is determined to be the most cost-effective restoration* to normal form and function.)

Facility Charges

This Plan covers inpatient or outpatient Hospital expenses for Dental-Related Services **only** if the patient is under age six or has a non-dental, hazardous physical condition (e.g., heart disease or hemophilia) that makes hospitalization Medically Necessary. All Hospital Services for dental-related and oral surgery services must obtain Prior Authorization from BCBSNM. **Note**: The Dentist's services for the procedure will not be covered unless listed as eligible for coverage in this section.

Reminder: If Hospital Covered Services are recommended by a Provider, you are responsible for assuring that the Provider obtains Prior Authorization for outpatient Covered Services or benefits may be reduced or denied. (See *Section 4: Utilization Management*.)

Oral Surgery

This Plan covers 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 or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required

TMJ/CMJ Services

This Plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) disorders or Accidental Injuries. Treatment may include orthodontic Appliances and treatment, crowns, bridges, or dentures **only if** required because of an Accidental Injury to Sound Natural Teeth involving the Temporomandibular or Craniomandibular Joint.

Exclusions

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

- surgeon's or Dentist's charges for non-Covered dental services
- hospitalization or general anesthesia for the patient's or Provider's convenience
- any service related to a dental procedure that is not Medically Necessary
- any service related to a dental procedure 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, work-related injuries, etc.)

- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, non-Covered Services, 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
- 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"
- dentures, artificial devices and/or bone grafts for denture wear, including implants

DIABETIC SERVICES

Diabetic persons 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, refer to the applicable provisions as noted below. **Note:** This 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 U.S. Food and Drug Administration.

For insulin and over-the-counter diabetic supplies, including glucose meters, contact the APS pharmacy benefit manager for more information.

For Durable Medical Equipment, see "Supplies, Equipment and Prosthetics."

For educational services and diabetes management services, see "Physician Visits/Medical Care."

Diabetes Self-Management Education

This Plan covers diabetes self-management training if you have diabetes or an elevated blood glucose due to pregnancy. Training must be prescribed by a Health Care Provider and given by a certified, registered, or licensed In-Network 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 with prescribing authority.
- Telephonic visits with a certified diabetes educator.
- medical nutrition therapy related to diabetes management.

Contact your pharmacy benefit manager for benefits for insulin and oral agents to control blood glucose levels, glucose meters, needles, syringes, and test strips; see "Supplies, Equipment and Prosthetics" for other covered supplies and equipment required due to diabetes.

Diabetic Supplies and Equipment

This Plan covers the following supplies and equipment for diabetic Members and individuals with elevated glucose levels due to pregnancy (supplies are not to exceed a 30-day supply purchased during any 30-day period):

- injection aids, including those adaptable to meet the needs of those with disabilities, including the legally blind.
- insulin pumps and insulin pump supplies
- blood glucose monitors, including for those with disabilities, including the legally blind.
- Medically Necessary Podiatric Appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications.

NOTE: This plan will also cover items not specifically listed as covered when new and improve equipment, appliances, and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration. This plan will:

- Maintain an adequate network of providers to provide these resources to individuals with diabetes.
- Guarantee reimbursement or coverage for the equipment, appliances, or Medical Supplies described in this Benefit Booklet within the limits of this Plan. (Coverage for prescription drugs, including insulin, is available through Express Scripts, the pharmacy benefit manager for your APS plan. Contact Express Scripts at (866) 563.9297.)**Reminder: Diabetic supplies and equipment are covered at 100% of covered charges when received from a Preferred Provider (equipment and supplies received from out-of-network providers are not covered).** For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, glucose meters, test strips for glucose monitors, glucagon Emergency kits), refer to the prescription drug plan Summary of Benefits.

EMERGENCY CARE AND URGENT CARE

Emergency Care

This Plan covers 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. (In addition, services must be received in an Emergency room, trauma center, or Ambulance to qualify as an Emergency.) Examples of Emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning. Non-Emergency services provided in an emergency room for treatment of Mental Disorders or Chemical Dependency will be paid the same as Emergency Care services.

Emergency Room Services

Use of an Emergency center for non-Emergency care is NOT covered. However, services will not be denied if you, in good faith and possessing average knowledge of health and medicine, seek care for what reasonably appears to be an Emergency — even if your condition is later determined to be non- Emergency.

Acute 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 and treatment must meet the definition of Emergency Care in order to be covered. Services received in an Emergency room that do not meet the definition of Emergency Care may be reviewed for appropriateness and may be denied. If you disagree with the Claim Administrator's determination in processing your benefits as non-Emergency Care instead of Emergency Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review *Section 8: Claims Payments and Appeals* section of this Policy for specific information on your right to seek and obtain a full and fair review of your Claim.

If you visit a Nonpreferred Provider for Emergency Care, the In-Network Provider benefit is applied only to the initial treatment, which includes Emergency room services and, if you are hospitalized **within 48 hours** of an Emergency, the related inpatient hospitalization. Once you are discharged, you will need to see a Preferred or Participating (In-Network) Provider for follow-up care as follow-up care from a Nonpreferred Provider is not covered. (Services received in an office or Urgent Care Facility are not considered Emergency Care for purposes of this provision.)

Services provided in an emergency room that are not Emergency Care may be excluded from emergency coverage, although these services may be covered under another benefit, if applicable. Emergency Care services – including non-Emergency services provided in an emergency room for Mental Disorders or Chemical Dependency – performed by a Nonpreferred Provider will be paid at the In-Network Provider level.

Emergency Admission Notification

To ensure that benefits are correctly paid and that an Admission you believe is Emergency-related will be covered, you or your Physician or Hospital should notify BCBSNM as soon as reasonably possible following Admission.

Follow-Up Care

For all follow-up care (which is no longer considered Emergency Care) and for all other non-Emergency Care, you will need to receive care from an in-network Provider in order for the services to be covered.

Member Copayments

If you are directly admitted as an inpatient, the Copayment for Emergency room services is waived. The inpatient Hospital benefit will apply in such cases.

Urgent Care

This Plan covers Urgent Care services, which means 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).

Urgent Care is covered as any other type of service. However, if services are received in an Emergency room or other trauma center, the condition and treatment must meet the definition of Emergency Care in order to be covered.

If you visit a Nonpreferred Provider for Urgent Care services, the Nationwide EPO Provider benefit is applied only to the initial treatment. After the initial Urgent Care treatment, you will need to see a Preferred or Participating (In-Network) Provider for follow-up care. Follow up care from a Nonpreferred Provider is not covered.

HEARING AIDS/RELATED SERVICES FOR CHILDREN UP TO AGE 21

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, **limited to one hearing aid, $2,200 maximum, per hearing-impaired ear every 36 months for dependent children only** under 21 years old. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing aid-related service, whichever length of time is greater.

Benefits for hearing aid-related services payable under this provision are not subject to any Coinsurance amount. Benefits for hearing aid-related services will be provided at **100 percent** of the Covered Charges. (Other Covered Services, such as hearing examinations and audiometric testing related to a hearing aid need for Members up to 21 years old are subject to the usual plan Coinsurance provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36-month maximum benefit available for hearing aids.) **Routine hearing examinations and related services are not covered for Members age 21 and older.**

HOME HEALTH CARE/HOME I.V. SERVICES

Conditions and Limitations of Coverage

If you are homebound (unable to receive medical care on an outpatient basis), this Plan covers Home Health Care Services and home I.V. services provided under the direction of a Physician. 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 Authorization Required

Before you receive home I.V. therapy, your Physician or Home Health Care Agency must obtain **Prior Authorization** from BCBSNM. **This Plan does not cover home I.V. services without Prior Authorization.**

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 a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other Prescription Drugs ordinarily not available through a Retail Pharmacy if **Prior Authorization** is received from BCBSNM (If drugs are not provided by the Home Health Care Agency, contact your pharmacy benefit manager for more information.*)*
- drugs, medicines, or laboratory services that would have been covered during an inpatient Admission
- enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, contact your pharmacy benefit manager for more information.)
- Medical Supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Cost Sharing

Your Copayment or Coinsurance and Deductible will be the same amount as shown on your *Plan Highlights* under primary care visits for Covered Services aimed at maximizing level of function, returning to a prior level of function, or maintaining or slowing the decline of function when these services are provided by a licensed or certified Physical Therapist, Occupational Therapist or Speech Therapist. Other Covered Services are subject to usual Member cost-sharing features such as Copayment or Coinsurance or Deductible based on the type of Provider, service or supply.

Exclusions

This Plan does **not** cover:

- care provided primarily for you 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 the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- services provided by a nurse who ordinarily resides in your home or is a Member of your immediate family
- private duty nursing

HOSPICE CARE SERVICES

Conditions and Limitations

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 and Prior Authorization is obtained from BCBSNM. 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. (See definition of a Hospice Benefit Period in *Section 10* for more information.)

Covered Services

This Plan covers the following services, subject to the conditions and limitations 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, contract your pharmacy benefit manager for more information.)
- 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
- respite care for a period **not to exceed five continuous days** for **every 60 days** of Hospice Care and **no more than two respite care periods** during each Hospice Benefit Period (*Respite care* provides a brief break from total care-giving by the family.)

Cost Sharing

Your Copayment or Coinsurance and Deductible will be the same amount as shown on your *Plan Highlights* under primary care visits for Covered Services aimed at maximizing level of function, returning to a prior level of function, or maintaining or slowing the decline of function when these services are provided by a licensed or certified Physical Therapist, Occupational Therapist or Speech Therapist. Other Covered Services are subject to usual Member cost-sharing features such as Copayment or Coinsurance or Deductible based on the type of Provider, service or supply.

Exclusions

This Plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services
- comfort items
- private duty nursing
- supportive services provided to the family of a Terminally Ill Patient when the patient is not a Member of this Plan
- care or services received after the Member's coverage terminates

HOSPITAL/OTHER FACILITY 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

Prior Authorization Required

If hospitalization is recommended by a Provider outside of New Mexico, **you are responsible** for obtaining Prior Authorization. If you do not follow the inpatient Prior Authorization procedures, benefits for covered Facility services will be **reduced or denied** as explained in *Section 4: Utilization Management.*

Covered Services

For acute inpatient medical or surgical care received during a covered Hospital Admission, this Plan covers room and board and other Medically Necessary services provided by the In-Network Facility.

Medical Detoxification

This Plan also covers Medically Necessary services related to Medical Detoxification from the effects of Alcohol or Drug Abuse. Detoxification is the treatment in an In-Network acute care Facility for withdrawal from the physiological effects of Alcohol or Drug Abuse, which usually takes about three days in an acute care Facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. Prior Authorization is required for all inpatient hospitalizations. See “Psychotherapy (Mental Disorder and Chemical Dependency)” for information about benefits for Chemical Dependency rehabilitation. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Exclusions

This Plan does **not** cover:

- Transplants or related services when Transplant received at a Facility that does not contract directly with a BCBSNM Participating Provider or through a BCBS Transplant network. (See "Transplant Services" for more information.)
- Admissions related to non-Covered Services or procedures
- Custodial Care Facility Admissions

Outpatient or Observation Services

Coverage for outpatient or observation services and related Physician or other Professional Provider services for the treatment of illness or Accidental Injury depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services" or "Emergency and Urgent Care").

INJECTIONS AND INJECTABLE DRUGS

This plan covers most FDA-approved therapeutic injections administered in a Provider's office. However, this plan covers some injectable drugs only when Prior Authorization is received from BCBSNM. Your BCBSNM-Contracted Provider has a list of those injectable drugs that require Prior Authorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request Prior Authorization, you may be directed to purchase the self-injectable medication through your prescription drug plan.)

BCBSNM reserves the right to exclude any injectable drug currently being used by a Member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM customer Service Advocate if you have any questions about this policy.

Exclusions

This Plan does **not** cover:

- This plan does **not** cover any self-administered drugs dispensed or administered by a Physician in his/her office.

LAB, X-RAY, OTHER DIAGNOSTIC 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 Diagnostic Services, including but not limited to, pre-Admission testing, that are related to an illness or Accidental Injury. Covered Services include:

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")
- infertility-related testing (See "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans, cardiac CT scans
- MRIs
- psychological or neuropsychological testing with **Prior Authorization** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an Accidental Injury or an illness

Note: All services, including those for which Prior Authorization is required, must meet the standards of Medical Necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this Plan.

Gynecological or obstetrical ultrasounds do not require Prior Authorization. Refer to the *Plan Highlights* for services that require Preauthorization. **Some services requiring Prior Authorization will not be approved for payment.**

Coronary Artery Calcification Tests

Early detection test for cardiovascular disease. This Plan covers a computed tomography (CT) scan measuring coronary artery calcifications (CAC) for Members between 45 and 65 years of age who have an intermediate risk of developing coronary heart disease. This Plan also covers scanning at five-year intervals for such Members who have previously received a CT scan measuring a CAC score of zero.

Diagnostic and Supplemental Breast Examinations

Benefits for Medically Necessary Diagnostic and Supplemental Breast Examinations will be provided without cost sharing when obtained from a Participating Provider.

MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

Like benefits for other conditions, Member cost-sharing amounts for pregnancy, family planning, infertility, and newborn care are based on the place of service and type of service received.

Family Planning and Infertility-Related Services

For Preventive oral contraceptive coverage and contraceptive devices purchased from a pharmacy, contract the APS pharmacy benefit manager for more information.

Family Planning

Covered family planning services include FDA-approved (if applicable) devices and other procedures such as:

- health education
- tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin - only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional method categories of contraception approved by the FDA
- pregnancy testing and counseling.
- vasectomies
- contraception methods that are prescribed for prevention of STI's, which means chlamydia, syphilis, gonorrhea, HIV, and relevant types of hepatitis, as well as any other sexually transmitted infections, regardless of mode of transportation.

For these following covered family planning services, no Coinsurance, Deductible, Copayment, or benefit maximums will apply when received from an in-network Provider. over-the-counter female contraceptives and male contraceptives

- the contraceptives list is posted on the BCBSNM website (www.bcbsnm.com) or available by contacting Customer Service at the toll-free number on your ID Card. For contraceptive medications and devices purchased from a pharmacy, contact the APS prescription drug plan.
- outpatient contraceptive services such as consultations, examinations, procedures (including follow-up care for trouble you may have from using a birth control method that a family planning Provider gave you) and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy
- female surgical sterilization procedures (other than hysterectomy), including tubal ligations
- contraception methods that are prescribed for the prevention of STIs, which means chlamydia, syphilis, gonorrhea, HIV, and relevant types of hepatitis, as well as any other sexually transmitted infections, regardless of mode of transportation.

When obtaining the items noted above, you may be required to pay the full cost and then submit a claim form with itemized receipts to BCBSNM for reimbursement. Please refer to *Section 8: Claims Payments and Appeals* of this Benefit Booklet for information regarding submitting claims. If benefits for contraceptive coverage are denied, you or your representative may contact Customer Service at the toll-free number on your ID Card to request an expedited review.

Infertility-Related Services

This Plan covers the following infertility-related treatments. (**Note:** the following procedures only *secondarily* treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas deferens 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.

Diagnostic *testing* is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be non-Covered, no further testing is covered. For example, this Plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a non-Covered infertility treatment.

Exclusions

In addition to services not listed as covered above, this Plan does **not** cover:

- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- 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, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception

Pregnancy-Related/Maternity Services

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery. If not notified, benefits for covered facility services may be reduced by **$300**.

A covered daughter also has coverage for Pregnancy-Related Services. However, if the parent of the newborn *is* a covered child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), benefits are **not** available for the newborn except for the first 48 hours of Routine Newborn Care (or 96 hours in the case of a C-section).

Covered Services

Covered Pregnancy-Related Services include:

- Hospital or other Facility charges for room and board 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. **Note:** Newborns who are not eligible for coverage under this Plan will not be covered beyond the 48 or 96 hours required under federal law.)
- 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 total Covered Charge for the actual delivery or completion of pregnancy.) **Note:** Home births are not covered.

- pregnancy-related diagnostic tests, including genetic testing or counseling (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or Alcohol Abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a Provider qualified to perform such services, including 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
- 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 surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of pregnancy prior to full term

Newborn Care

You must add coverage within 60 days of birth in order for any newborn charges, routine or otherwise, to be covered. Contact the APS Employee Benefits Department to enroll your newborn.

Newborn Eligibility

If you do not elect to add coverage for your newborn within 60 days, and wish to add the child to coverage later, the child is considered a Late Applicant unless eligible for a Special Enrollment. **Note:** If the parent of the newborn is a covered child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), services for the newborn are **not** covered except for the first 48 hours of Routine Newborn Care (or 96 hours in the case of a C-section).

Routine Newborn Care

If both the mother's charges and the baby's charges are eligible for coverage under this Plan, no additional Deductible for the newborn is required for the Facility's initial routine nursery care if the covered newborn is discharged on the same day as the mother.

Covered Services

Covered Services for initial Routine Newborn Care include:

- routine Hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the Hospital after delivery
- pediatrician standby care at a C-section procedure
- services related to circumcision of a male newborn

For children who are covered from their date of birth, benefits include coverage of injury or sickness, including Covered Services related to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if he/she stays in the Hospital longer than the mother. The baby's services will be subject to a separate Deductible, Coinsurance and Out-of-Pocket Limit.

Note: You must 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.

PHYSICIAN VISITS/MEDICAL CARE

This section describes benefits for therapeutic injections, allergy care and testing, and other nonsurgical, nonroutine medical visits to a Health Care Provider for evaluating your condition and planning a course of treatment. See specific topics referenced in this section for more information regarding a particular type of service (e.g., "Preventive Services," "Transplant Services," etc.).

This Plan covers Medically Necessary care provided by an In-Network Physician or other In-Network Professional Provider for an illness or Accidental Injury. (See *Section 3: How Your Plan Works*.)

Office Visits and Consultations

Benefits for services received in a Physician's office are based on the type of service received while in the office. Services covered under this provision include allergy care, therapeutic injections, office visits, consultations (including second or third surgical opinions) and examinations, and other nonroutine office medical procedures — when not related to Hospice Care or payable as part of a surgical procedure. (See "Hospice Care" or "Surgery and Related Services" if the medical visits are related to either of these services.)

Allergy Care

This Plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), allergy serum, and appropriate FDA-approved allergy injections administered in a Provider's office or in a Facility.

Breastfeeding Support and Services

This Plan covers counseling and support services rendered by a lactation consultant such as a Certified Nurse Practitioner, Certified Nurse Midwife or midwife, not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from an in-network Provider.

Genetic Inborn Errors of Metabolism

This Plan covers medically necessary expenses related to the diagnosis, monitoring and control of genetic inborn errors of metabolism as defined in *Section 10: Definitions.* Covered services include medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs (Contact the APS pharmacy benefit manager), corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and special medical foods (as defined and described in pharmacy benefits). In order to be covered, services cannot be excluded under any other provision of this Benefit Booklet and are paid according to the provisions of the Plan that apply to that particular type of service (e.g., special medical foods are covered under pharmacy benefits medical assessments under "Physician Visits/Medical Care" and corrective lenses under "Supplies, Equipment and Prosthetics").

To be covered, the Member must be receiving medical treatment provided by licensed Health Care Professionals, including Physicians, dieticians and nutritionists, who have specific training in managing patients diagnosed with Genetic Inborn Errors of Metabolism.

Injections and Injectable Drugs

This Plan covers most FDA-approved therapeutic injections administered in a Provider's office. However, this Plan covers some injectable drugs only when Prior Authorization is received from BCBSNM. Your BCBSNM-Contracted Provider has a list of those injectable drugs that require Prior Authorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request Prior Authorization, you may be directed to purchase the self-injectable medication through your prescription drug plan.)

The Claims Administrator and the Plan reserves the right to exclude any injectable drug currently being used by a member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Customer Service Advocate if you have any questions about this policy.

Mental Disorder Evaluation Services

This Plan covers medication checks and intake evaluations for Mental Disorders, Alcohol, and Drug Abuse from In-Network Providers. See "Psychotherapy (Mental Disorder and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

With the exception of Dental-Related Services, this Plan covers the following services when received on a covered inpatient Hospital day:

- visits for a condition requiring **only** medical care, unless related to 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" or "Transplant Services.")
- medical care requiring **two or more** Physicians at the same time because of multiple illnesses
- initial Routine Newborn Care for a newborn added to coverage within the time limits specified in *Section 2: Enrollment and Termination Information* (See "Maternity/Reproductive Services and Newborn Care" for details and for extended stay benefits.)

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 under this provision 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. Coverage for a recommended Preventive Service that is otherwise considered Medically Necessary for an individual will be provided regardless of an individual's sex assigned at birth, gender identity or gender that BCBSNM has recorded.

This Plan covers the following Preventive Services, and they will not be subject to Coinsurance, Deductible, Copayment, or benefit maximums (to be implemented in the quantities and within the time period allowed under applicable law) when received from an In-Network Provider.

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved (note that immunizations are generally covered under the APS prescription drug plan, not under the medical plan.);
c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
d. with respect to women, such additional preventive care and screenings not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA.
e. Direct links to covered Preventive Services are:

   - adults https://www.healthcare.gov/preventive-care-adults/
   - women https://www.healthcare.gov/preventive-care-women/
   - children https://www.healthcare.gov/preventive-care-children/

For purposes of item "a" above, the current recommendations of the USPSTF regarding breast cancer screening mammography and prevention issued in or around November 2009 are not considered to be current.

Preventive drugs (including both prescription and over the counter products) that meet the preventive recommendation outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable. (Coverage for prescription drugs is available through Express Scripts, the pharmacy benefit manager for your APS plan. Contact Express Scripts at (866) 563.9297.)

Covered Preventive Services **not** described in items "a" through "d" above may be subject to Deductible, Coinsurance, Copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit.

The list below is subject to change. You can contact customer service at 1-800-432-0750.

Preventive Care Services for Adults (or others as specified):

- Abdominal aortic aneurysm screening for men ages 65 to 75 who have never smoked.
- Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions.
- Unhealthy alcohol and drug use screening and counseling.
- Blood pressure screening.
- Colorectal cancer screening for adults age 45 and over.
- Depression screening.
- Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease factors for cardiovascular disease.
- HIV screening for all adults at higher risk.
- HIV preexposure prophylaxis (PrEP)_with effective antiretroviral therapy for persons at high risk of HIV acquisition.
- The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary): Note that immunizations are generally covered under the APS prescription drug plan, not under the medical plan.
    - Haemophilus influenzae type b (Hib)
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster (Shingles)
    - Human papillomavirus
    - Influenza (Flu shot or Flu mist)
    - Measles, Mumps, Rubella
    - Meningocaccal
    - MPOX
    - Pnemococcal
    - RSV
    - Tetanus, Diphtheria, Pertussis
    - Varicella
    - COVID-19
- Obesity screening and counseling
- Sexually transmitted infections (STI) counseling.
- Tobacco use screening and cessation interventions for tobacco users.
- Syphilis screening for adults and adolescents at higher risks.
- Exercise interventions to prevent falls in adults age 65 and older who are at increased risk for falls.
- Hepatitis C virus (HCV) screening infection in adults aged 18 to 79 years.
- Hepatitis B virus screening for adults and adolescents at high risk for infection.
- Counseling Children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

- Lung cancer screening in adults 50 and older who have a 20-pack a year smoking history and currently smoke or have quit within 15 years.
- Screening for high blood pressure in adults age 18 years or older.
- Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese.
- Low to moderate-dose statin for the prevention of cardiovascular disease (for adults aged 40 to 75 years with: a) no history of CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater.
- Tuberculin testing for adults 18 years or older who are at risk for tuberculosis.

Preventive Care Services for Women (including pregnant women or others as specified):

- Bacteriuria urinary tract screening or other infection screening for pregnant women.
- BRCA counseling about genetic testing for women at high risk.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive lactation support and counseling from trained providers as well as access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to one per benefit period.
- Cervical cancer screening
- Chlamydia infection screening for younger women and women at higher risk.
- Counseling for pregnant women to promote healthy weight gain and preventing excess gestational weight gain.
- Domestic and interpersonal violence screening and counseling for all women.
- Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for women.
- Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 and older.
- Osteoporosis screening for women over age 65 and younger women with risk factors.
- Perinatal depression screening and counseling.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Sexually transmitted infections (STI) counseling.
- Syphilis screening for all pregnant women or other women at increased risk.
- Breast cancer mammography screening for women age 40-74.
- Aspirin use for pregnant woman to prevent preeclampsia.
- Screening for preeclampsia in pregnant woman with blood pressure measurements throughout pregnancy.
- Urinary incontinence screening.
- Well-Woman visits.

Preventive Care Services for Children (or others as specified):

- Anxiety screening for Children and adolescents.
- Depression screening for adolescents.
- Fluoride chemoprevention supplements for Children without fluoride in their water source.
- Fluoride varnish to primary teeth of all infants and Children starting at the age of primary tooth eruption.
- Gonorrhea prevention medication for the eyes of newborns.
- HIV screening for adolescents at higher risk.
- Obesity screening and counseling.
- Sexually transmitted infections (STI) prevention and counseling for adolescents.
- Vision screening for Children and adolescents.
- Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged Children and adolescents.
- Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder when provided as part of a well-baby or well-child visit.

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; sports or camp physicals; any other non preventive physical examination
- routine eye examinations; eye refractions; or any related service or supply
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section (See “Hearing Aids/Related Services for Children Under Age 21.”)

Note: BCBSNM Preventive Care Guidelines may be found at the BCBSNM website below or contacting Customer Services: www.bcbsnm.com/provider/clinical/clinical-resources/preventive-care-guidelines.

PSYCHOTHERAPY (MENTAL DISORDER AND CHEMICAL DEPENDENCY)

Note: You do not receive a separate Mental Disorder/Chemical Dependency ID Card; use your BCBSNM ID Card to receive all medical/surgical and Mental Disorder/Chemical Dependency services covered under this Plan. Outpatient professional Behavioral Health Services do not require a referral.

Medical Necessity

In order to be covered, treatment must be Medically Necessary and not Experimental, Investigational or Unproven, and must be provided by an In-Network Provider (except in the case of Emergency Care). Therapy must meet the following definition and conditions:

Medically Necessary/Medical Necessity is defined as 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 Disorder condition, illness, injury, or disease.

For Psychotherapy (Mental Disorder and Chemical Dependency) Medical Necessity determinations, the applicable generally accepted principles and practices of good medical care and practices guidelines developed by the American Psychiatric Association are contained in the latest version of the *Diagnostic and Statistical Manual.*

Prior Authorization Requirements

Prior Authorization are a requirement that you or your Provider must obtain authorization from BCBSNM *before* you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

- services must be covered and Medically Necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

Prior Authorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. **Prior Authorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits.** Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this Plan, and services that are not Medically Necessary will be denied.

Services Requiring Prior Authorization

Prior Authorization for all inpatient Mental Disorder and Chemical Dependency services (e.g., partial hospitalization, Residential Treatment Centers) must be approved by the Behavioral Health Unit at the phone number listed on the back of your ID Card. Prior Authorization is also required for the following Outpatient Services for treatment of Mental Illness and/or Chemical Dependency:

- outpatient psychological testing
- neuropsychological testing
- Intensive Outpatient Program (IOP) treatment
- electroconvulsive therapy (ECT)
- repetitive transcranial magnetic stimulation
- Applied Behavior Analysis (ABA) therapies

You or your Physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving non-Emergency services, **benefits for Covered Services may be denied** as explained in Section 4: *Utilization Management*. In such cases, you may be responsible for all charges, so please ensure that

you or your Provider have received Prior Authorization for any services you plan to receive. The BHU Call Center is open 24/7 to assist Members and Providers with Emergency Admission inquiries and to respond to crisis calls.

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), **both Admissions must receive Prior Authorization**.

Prior Authorization is **not** required for group, individual, or family therapy office visits to a Physician or other Professional Provider licensed to perform Covered Services under this Plan, or for the following mental health or substance use disorder services:

- Acute or immediately necessary care
- Acute episodes of chronic mental health or substance use disorder conditions; or
- Initial in-network inpatient or outpatient substance use treatment services.

Covered Services/Providers

Covered Services include solution-focused evaluative and therapeutic Mental Disorder services (including individual and group psychotherapy) received in a Psychiatric Hospital, an IOP (Intensive Outpatient Program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed Psychologists, and Other Providers as defined in *Section 10: Definitions*. See your BCBSNM *Provider Directory* for a list of contracting Providers or check the BCBSNM website at www.bcbsnm.com.

Residential Treatment Centers

Residential Treatment Centers are covered by this Plan. A Residential Treatment Center is a Facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other Facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such Facilities. Patients in Residential Treatment Centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with Mental Illness and/or Chemical Dependency disorders.

BCBSNM requires that any Mental Disorder Residential Treatment Center must be appropriately licensed in the state where it is located or accredited by a national organization that is recognized by BCBSNM as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Exclusions

This Plan does **not** cover:

- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home, or their staff Members; foster care; or behavior modification services
- maintenance therapy or care provided after you have reached your rehabilitative potential (See the "Long-Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)
- hypnotherapy, or behavior modification services
- religious or pastoral counseling
- Custodial Care (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- hospitalization or Admission to a Skilled Nursing Facility, nursing home, or other Facility for the primary purpose of providing Custodial Care Service, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an Inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. Services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and Mental Disorder conditions) are not excluded services
- any care that is patient-elected and is not considered Medically Necessary

- 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.
- 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 Disorders or other disturbances.
- non-national standard therapies, including those that are Experimental as determined by the Mental Disorder professional practice.
- the cost of any damages to a treatment Facility

REHABILITATION AND OTHER THERAPY

When billed by a Preferred or Participating (In-Network) Facility during a covered Admission, therapy is covered in the same manner as the other ancillary services (see "Hospital/Other Facility Services").

Acupuncture and Spinal Manipulation

This Plan covers Acupuncture and Osteopathic or Spinal Manipulation services (application of manual pressure or force to the spine) when administered by a licensed, In-Network Provider acting within the scope of licensure and when necessary for the treatment of a medical condition. Benefits for Acupuncture and for Spinal Manipulation are limited as specified in the *Plan Highlights*. **Note:** If your Provider charges for other services in addition to Acupuncture or Manipulation, the other services will be covered according to the type of service being claimed. For example, physical therapy services from a Provider on the same day as an Acupuncture or Spinal Manipulation service will apply toward the "Short-Term Rehabilitation" benefit.

Note: Benefits for Chiropractic Services will not be subject to a Copayment or Coinsurance that exceeds the Copayment or Coinsurance for primary care services.

Cardiac and Pulmonary Rehabilitation

This Plan covers outpatient Cardiac Rehabilitation programs provided within six months of a cardiac incident and outpatient Pulmonary Rehabilitation services.

Chemotherapy and Radiation Therapy

This Plan covers the treatment of malignant disease by standard Chemotherapy and treatment of disease by Radiation Therapy.

Habilitative and Rehabilitative Services

Benefits will be provided for Medically Necessary Habilitative Services, which includes coverage for prosthetic and custom orthotic devices.

Cancer Clinical Trials

If you are a participant in an approved Cancer Clinical Trial, you may receive coverage for certain Routine Patient Care Costs 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 re-occurrence, early detection, or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the Member enters and leaves a qualified Cancer Clinical Trial and must accept BCBSNM's Covered Charges as payment in full (this includes the health care 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 supplier of the drug. (Member cost-sharing provisions described under your prescription drug plan Summary of Benefits will apply to these benefits.)

Benefits for Routine Patient Care Costs for Participation in Certain Clinical Trials

Benefits for eligible expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial

and that are customarily paid for by the research institution conducting the clinical trial.

Dialysis

This Plan covers the following services when received from a Dialysis Provider:

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

Short-Term Rehabilitation: Occupational, Physical, Speech Therapy (Inpatient and Outpatient, Including Skilled Nursing Facility)

Prior Authorization Required

To be covered, all **inpatient**, Short-Term Rehabilitation treatments, including Skilled Nursing Facility and physical rehabilitation Facility Admissions, must receive **Prior Authorization** from BCBSNM. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Covered Services

This Plan covers the following Short-Term Rehabilitation services when rendered 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)
- Joint and Spinal Manipulation services when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of Accidental Injury or medical condition
- 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 when **Prior Authorization is obtained** from BCBSNM

Cost Sharing

Your Copayment or Coinsurance and Deductible will be the same amount as shown on your *Summary of Benefits* under primary care visits for Covered Services aimed at maximizing level of function, returning to a prior level of function, or maintaining or slowing the decline of function when these services are provided by a licensed or certified Physical Therapist, Occupational Therapist or Speech Therapist. Other Covered Services are subject to usual Member cost-sharing features such as Copayment or Coinsurance or Deductible based on the type of Provider, place of treatment or type of service.

Benefit Limits

Benefits are limited, if applicable, as specified in the *Plan Highlights*. Benefits for Autism Spectrum Disorder will not apply toward, and are not subject to, any Occupational Therapy, Physical Therapy or Speech Therapy visits. **Note:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This Plan covers short-term rehabilitation only.

Exclusions

This Plan does **not** cover:

- 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 exceed maximum benefit limits, if any.)

- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay and described in this *Covered Services* section under "Autism Spectrum Disorders"
- services 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
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist
- drug therapy that has not received Prior Authorization

SUPPLIES, EQUIPMENT AND PROSTHETICS

To be covered, items must be Medically Necessary and ordered by a Health Care Provider. If you have a question about Durable Medical Equipment, Medical Supplies, Prosthetics or Appliances not listed, please call the BCBSNM Health Services Department.

Breast Pumps

This plan covers the rental (but not to exceed the total cost) or purchase of manual, electric, or Hospital grade breast pumps and supplies with a written prescription from a Health Care Provider. The rental or purchase cost of manual, electric, or Hospital grade breast pumps and supplies are not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from an In-Network Provider. Electric breast pumps are limited to one (1) per Calendar Year.

Durable Medical Equipment and Appliances

This Plan covers the following items**:**

- Orthopedic Appliances
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, Hospital beds, crutches, and other Medically 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 needed 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 is covered only if a Physician or Optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers

Medical Supplies

This Plan covers the following Medical Supplies, not to exceed a **34-day supply** purchased during any 34-day period, unless otherwise indicated:

- 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
- support hose prescribed by a Physician for treatment of varicose veins (six pair per Calendar Year)

Orthotics and Prosthetic Devices

This Plan covers the following items when Medically Necessary and ordered by a Provider:

- surgically implanted Prosthetics or devices, including but not limited to, penile implants required as a result of illness or Accidental Injury
- 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 and mastectomy bras, which are limited to **three bras** per Calendar Year
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and prescribed by a Physician or Podiatrist.)
- orthotics (e.g., collars, braces, molds) prescribed by an eligible Provider to protect, restore, or improve impaired body function
- prosthetics for Medically Necessary primary gender reassignment chest and/or genital surgeries, including but not limited to breast implants, implantable erectile prosthesis, and placement of testicular prothesis when meeting the criteria for gender dysphoria.

When alternative Prosthetic Devices are available, the allowance for a prosthesis will be based upon the most Cost-Effective item.

This Plan covers the rental (or at the option of BCBSNM, the purchase of) Durable Medical Equipment (including repairs to or replacement of such purchased items), when prescribed by a covered Health Care Provider and required for therapeutic use. Unlike diabetic supplies and equipment, Durable Medical Equipment and appliances for other medical conditions is subject to Coinsurance as indicated on the Plan Highlights.

Exclusions

This Plan does **not** cover, regardless of therapeutic value, items such as, but not limited to:

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are 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, chairlifts or beds.
- repairs to items that you do not own
- comfort items such as bed boards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit
- dental Appliances (See “Dental-Related Services and Oral Surgery” for exceptions.)
- 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 should refer to “Diabetic Supplies and Equipment” earlier in this section for information about covered podiatric equipment and orthopedic shoes.)

- equipment or supplies not ordered by a Health Care Provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- eyeglasses or contact lenses or 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
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies for persons 21 or older or, if under age 21, in excess of the maximum benefit described in this section (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services" below.)
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under your pharmacy benefits.)
- items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- items not listed as covered

SURGERY AND RELATED SERVICES

To be covered, Prior Authorization from BCBSNM must be received for all inpatient surgical procedures. See "Utilization Management" in *Section 4* for details.

Surgeon's Services

Covered 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.

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 reconstructive breast surgery following a covered mastectomy. Coverage is limited to:

- surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures
- the initial surgery of the other breast to produce a symmetrical appearance
- 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.

Obesity Surgery

This Plan covers the surgical treatment of Morbid Obesity if treatment meets medical criteria established by BCBSNM. Medical policies are posted on BCBSNM's website (http://hcsc.com/medical_policies.html) and may change without notice. Check the website for the most current medical policy or call a Customer Service Advocate for assistance. *(Morbid Obesity* means 45 kilograms or 100 percent over ideal body weight.)

Obesity (Bariatric) Surgery and Weight Loss Programs

Surgical treatment of morbid obesity is covered only if is a Medically Necessary and Prior Authorization has been obtained from BCBSNM before treatment beings. Bariatric surgery is covered for patients with a Body Mass Index (BMI) of 35 kg m2 or greater who are at high risk for increased morbidity due to a specific obesity related co-morbid medical condition(s); and if a Member meets these criteria and all other requirements of this plan. This plan also covers dietary evaluations and counseling for their medical management of morbid obesity.

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. This Plan covers Reconstructive Surgery 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," above.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

Cosmetic procedures and procedures that are **not Medically Necessary**, including all services related to such procedures, may be **denied.**

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")
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of Medically Necessary diabetic disease management, trimming of corns, calluses, toenails, or 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 non-Covered procedure (such as a non-Covered Organ Transplant, or previous Cosmetic surgery)
- the insertion of artificial organs, or services related to Transplants not specifically listed as covered under "Transplant Services"
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby Physician actually assists

Anesthesia Services

This Plan covers necessary anesthesia services, including Acupuncture used as an anesthetic, when administered during a covered surgical procedure by a Physician, Certified Registered Nurse Anesthetist (CRNA), or other practitioner licensed to provide anesthesia.

Exclusions

This Plan does **not** cover local anesthesia except for colonoscopies. (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
- services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon

TRANSPLANT SERVICES

Prior Authorization, requested in writing, must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if Prior Authorization is not obtained from BCBSNM. If approved, 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 Authorization for the actual Transplant is also received. None of the benefits described here are available unless you have this Prior Authorization. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Facility Must Be in Transplant Network

Benefits for Covered Services will be approved only when the Transplant is performed at a Facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS Transplant network, for the Transplant being provided. Your BCBSNM case manager will assist your Provider with information on the exclusive network of Contracted Facilities and required approvals. Call BCBSNM Health Services for information on these BCBSNM Transplant programs.

Effect of Medicare Eligibility on Coverage

If you are now eligible for (or are *anticipating* receiving eligibility for) Medicare benefits, **you** are solely responsible for contacting Medicare to ensure that the Transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses

If a Transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires surgery to make an organ available for a covered Transplant, coverage is available for expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow-up care only.

This Plan does **not** cover donor expenses after the donor has been discharged from the Transplant Facility. Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Bone Marrow, Cornea or Kidney

This Plan covers the following Transplant procedures if **Prior Authorization** is received from BCBSNM (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.):

- bone marrow Transplant for a Member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by BCBSNM to be Medically Necessary and not Experimental, Investigational, or Unproven
- cornea Transplant
- kidney Transplant

Cost-Sharing Provisions

Covered Services related to the above Transplants are subject to the usual cost-sharing features and benefit limits of this Plan (e.g., Deductible, Coinsurance and Out-of-Pocket Limits; and annual home health care maximums, if applicable).

Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney

This Plan covers Transplant-Related Services for a **heart, heart-lung, liver, lung or pancreas-kidney** Transplant. Prior Authorization for services is required in order to be covered. All other limitations, requirements, and exclusions of this "Transplant Services" provision apply to these Transplant-Related Services. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

In addition to the general provisions of this "Transplant Services" section, the following benefits, limitations, and exclusions apply to the above-listed Transplants for **one year** following the date of the actual Transplant or retransplant. After one year, usual benefits apply and the services must be covered under other provisions of the Plan in order to be considered for benefit payment.

Recipient Travel and Per Diem Expenses

If BCBSNM requires you (i.e., the Transplant recipient) to temporarily relocate outside of your city of residence to receive a covered Transplant, travel to the city where the Transplant will be performed is covered. A standard

per diem benefit **($50)** will be allocated for lodging expenses for the recipient and one additional adult traveling with the Transplant recipient. If the Transplant recipient is an Eligible Child under the age of 18, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit of **$10,000** per Transplant. Your case manager may approve travel and per diem lodging allowances based upon the total number of days of temporary relocation, up to the **$10,000** benefit maximum.

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 or if the travel occurs **more than five days** before or **more than one year** following the Transplant or retransplant date.

Transplant Exclusions

This Plan does **not** cover:

- Transplant-Related Services for a Transplant that did not receive **Prior Authorization** from BCBSNM (See *Section 4: Preauthorizations* for more information about Preauthorization requirements.)
- any Transplant or organ-combination Transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM medical policy)
- nonhuman organ Transplants
- care for complications of non-Covered Transplants or follow-up care related to such Transplants
- services related to a Transplant performed in a Facility not contracted directly or indirectly with BCBSNM to provide the required Transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a Member of this plan for the donation of an organ to another person who is not a member of this plan
- drugs that are self-administered or for use while at home (These services may be covered under your *pharmacy benefits.*)
- donor expenses after the donor has been discharged from the Transplant Facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
  - incurred **more than five days before** or **more than one year following** the date of transplantation
  - if the recipient's case manager indicates that travel is not Medically Necessary
  - related to a bone marrow or kidney Transplant
- 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 transportation received from a Member of your family, or from any other person charging for transportation that does not ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** services listed in this Benefit Booklet.

This Plan does not cover any service or supply not specifically listed as a Covered Service in this Benefit Booklet. This Plan does not cover services or supplies received from out-of-network providers except as specifically listed in this Benefit Booklet. If a service is not covered, then all services performed in conjunction with it are not covered.

This Plan will not cover any of the following services, supplies, situations, or related expenses:

— Before Effective Date of Coverage

This Plan does not cover any service received, item purchased, or health care expense incurred before your Effective Date of Coverage. If you are an inpatient when 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.

— Blood Services

This Plan does not cover directed donor or autologous blood storage fees when the blood is used during a non-scheduled surgical procedure. **This Plan does not cover** blood replaced through donor credit.

— Cannabis

This plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plan, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be call marijuana.

— Complications of non-Covered Services

This Plan does not cover any services, treatments, or procedures required as the result of complications of a non-Covered Service, treatment, or procedure (e.g., due to a 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, 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.**

The cosmetic coverage exclusion does not apply to Medically Necessary primary gender reassignment chest and/or genital surgeries nor to pharmaceutical gender reassignment services, all of which require prior authorization from BCBSNM.

Exception: Breast/nipple surgery performed as reconstructive procedures following a covered mastectomy may be covered. However, **Prior Authorization**, requested in writing, must be obtained from BCBSNM for such services. Also, Reconstructive Surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of Accidental Injury, illness, or congenital defect.

— Custodial Care

This Plan does not cover Custodial Care. Custodial Care is any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care includes those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel assisting with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.), and/or assisting with activities of daily living (e.g., bathing, eating, dressing, etc.).

— Dental-Related Services and Oral Surgery

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Dental-Related Services and Oral Surgery" in *Section 5: Covered Services* for additional exclusions.

— 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 7: Coordination of Benefits and Reimbursement* 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 of Coverage under this Plan that are covered under the prior plan's extension of benefits provision.

— 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) or those considered Experimental, Investigational, or Unproven, unless for Acupuncture rendered by a licensed Doctor of Oriental Medicine or unless specifically listed as covered under "Autism Spectrum Disorders" or under "Cancer Clinical Trials" in *Section 5: Covered Services*. 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, Investigational, or Unproven, 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 (FDA), 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, 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, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

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 exclusion in this Benefit Booklet.

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.

— Food or Lodging Expenses

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

— Genetic Testing or Counseling

This Plan does not cover tests such as amniocentesis or ultrasound to determine the gender of an unborn child. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for details.

— 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 Examinations, Procedures and Aids

This Plan does not cover audiometric (hearing) tests **unless** 1) required for the diagnosis and/or treatment of an Accidental Injury or an illness, or 2) covered as a preventive *screening* service, or 3) covered as part of the hearing aid benefit for Members under age 21 and described under "Hearing Aids/Related Services for Children under Age 21" in *Section 5: Covered Services.* (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This Plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for **Members age 21 and older.** For **Members** under **age 21**, see "Hearing Aids/Related Services for Children under Age 21" in *Section 5.* (For surgically implanted devices, see "Surgery and Related Services" in *Section 5: Covered Services.*)

— Home Health, Home I.V. and Hospice Services

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

— Hypnotherapy

This Plan does not cover hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

— 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), 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 "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services*.)

— Late Claim 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. Only Emergency and Urgent Care services from Nonparticipating Providers are covered on this EPO Plan. (Preferred Providers contracting directly with BCBSNM and Providers that have a "Participating" Provider agreement with BCBSNM will file Claims for you and must submit them within a specified period of time, usually 180 days.) 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 *Section 8: Claims Payments and Appeals* 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 "Autism Spectrum Disorders" in *Section 5: Covered Services* for details about mandated coverage for children with these diagnoses.

— 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.

— 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 and 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, muscular dystrophy, Down's syndrome, and cerebral palsy.) **Note:** This exclusion does **not** apply to benefits for medication or medication management or to certain services covered for children with Autism Spectrum Disorders.

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 Tourism

This Plan does not cover any services and/or supplies provided to a Member outside the United States if the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs.

— Medical Necessity Guidelines Determinations

Any technologies, procedures, or services for which Medical Necessity Guidelines have been developed by BCBSNM are either limited or excluded as defined in the Medical Necessity Guidelines.

— Medically Unnecessary Services

This Plan does not cover services that are not Medically Necessary as defined in *Section 5: Covered Services* unless such services are specifically listed as covered (e.g., see "Preventive Services" or "Autism Spectrum Disorders" in *Section 5: Covered Services*).

BCBSNM, in consultation with the 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. (BCBSNM, at its sole discretion, determines Medical Necessity based on the criteria given in *Section 5: Covered Services*.)

— 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 Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

Note: The "No Legal Payment Obligation" exclusion does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services, and Medicaid.

— Non-Covered 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
  - — massage therapist
  - — private sanitarium
  - — dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - — homeopathic or naturopathic Provider

— Non-Covered Services

This Plan does not cover any related services to a non-covered service. Related Services are:

- services in preparation for the non-covered service;
- services in connection with providing the non-covered service;
- hospitalization required to perform the non-covered service; or
- services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

— Non-Emergency Services

This Plan does not cover non-Emergency services outside the United States.

— 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 "Physician Visits/Medical Care" and "Preventive Services" in *Section 5: Covered Services* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; "get-acquainted" visits without physical assessment or medical care; provision of medical information to perform Admission review or other Prior Authorizations; filling out of Claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- 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; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, medical research programs, sports, or for any non-preventive purpose
- hepatitis B immunizations when required due to possible exposure during the Members work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment Facility that are caused by the Member

— Nonpreferred Provider Services

This Plan does not cover services received from a Nonpreferred (Out-of-Network_Provider, except Emergency and Urgent Care services as indicated in this Benefit Booklet.

— Nutritional Supplements

This Plan does not cover vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, unless prescribed by a Physician. Such supplements require a prescription to be covered under the "Home Health Care/Home I.V. Services" in *Section 5: Covered Services.*

— Post-Termination Services

This Plan does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) Prior Authorization 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 ends, benefits for the Admission will be available only for those Covered Services received before your termination date.)

— Prior Authorization Not Obtained When Required

This Plan does not cover certain services if you do not obtain Prior Authorization from BCBSNM before those services are received. See *Section 4: Utilization Management.*

— Private Duty Nursing Services

This Plan does not cover private duty nursing services.

— Psychotherapy (Mental Disorder and Chemical Dependency)

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Psychotherapy (Mental Disorder and Chemical Dependency)" in *Section 5: Covered Services* for additional exclusions.

— 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, see "Supplies, Equipment and Prosthetics" in *Section 5: Covered Services* for additional exclusions.

— Surgery and Related Services

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Surgery and Related Services" in *Section 5: Covered Services* 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 Benefit Booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this section, (see "Rehabilitation and Other Therapy" in *Section 5: Covered Services* for additional exclusions) **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 and codependency programs
- smoking/tobacco use Cessation Counseling programs that do not meet the standards described under "Cessation Counseling" in *Section 10: Definitions*
- services of a massage therapist
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling
- supportive services provided to the family of a Terminally Ill Patient when the patient is not a Member of this Plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay and described in *Section 5* under "Autism Spectrum Disorders"
- any therapeutic exercise equipment 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

— 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 5: Covered Services* 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, **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 expenses, even if travel is necessary to receive Covered Services unless such services are eligible for coverage under "Transplant Services" or "Ambulance Services" in *Section 5: Covered Services*.

— 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 refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual refractive defect (e.g., farsightedness or astigmatism). **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 5: Covered Services.* **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.

— 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 laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations.
- You obtain care not authorized by Workers' Compensation insurance.
- Your spouse/domestic partner or child's 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: This "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 are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

For a work-related injury or condition, see the "Work-Related Conditions" exclusion in Section 6: General Limitations and Exclusions.

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. (Other Valid Coverage is defined as all other Group and individual (or direct-pay) insurance policies or health care plans including Medicare, but excluding Indian Health Service and Medicaid coverages, that provide payments for medical services and are considered Other Valid Coverage for purposes of coordinating benefits under this Plan.)

If you are also covered by Medicare, special COB rules may apply. Contact a Customer Service Advocate 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.

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

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 not secondary according to federal law, Medicare pays first.

Child/Spouse — If a covered child under this health plan is covered as a spouse under another health plan, the covered child's spouse's health plan is primary over this health plan.

Subscriber/Family Member — If the Member who received care is covered as an employee, retiree, or other policy holder (i.e., as the Subscriber) under one health plan and as a spouse, child, or other family member under another, the health plan that designates the Member as the employee, retiree, or other policy holder (i.e., as the Subscriber) pays first.

If you have Other Valid 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.

Child — For a 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 Valid Coverage does not follow this rule, the father's coverage pays first.

Child, Parents Separated or Divorced — For a 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 family member 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.)

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.

Overpayments - 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

If you or one of your covered family members 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:

- **Albuquerque Public Schools** has 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 and your legal representative as a result of that sickness or injury, in the amount of the total Covered Charges for Covered Services for which **Albuquerque Public Schools** has provided benefits to you or your covered family members.
- **Albuquerque Public Schools** is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits **Albuquerque Public Schools** provided for that sickness or injury.

Albuquerque Public Schools shall have the right to first reimbursement out of all funds you, your covered family members, or your legal representative, are or were able to obtain for the same expenses for which **Albuquerque Public Schools** 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 and/or **Albuquerque Public Schools** may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 8: CLAIMS PAYMENTS AND APPEALS

IMPORTANT NOTE ABOUT FILING CLAIMS

This section addresses the procedures for filing Claims Payments 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 Prior Authorization requirements or benefits may be denied as explained in *Section 4: Utilization Management*. Covered Services are the same services listed as covered in *Section 5: Covered Services* and all services are subject to the limitations and exclusions listed throughout this booklet.

CLAIM FORMS AND PROOF OF LOSS

Written proof of loss must be furnished to BCBSNM in accordance with the Claim procedures specified in this *Section 8: Claims Payments and Appeals*. Proof may be submitted either electronically or on paper. Written notice of Claim must be given to BCBSNM within 365 days after the occurrence or start of the loss on which the Claim is based. If notice is not given in that time, the Claim will not be invalidated or denied if it is shown that written notice was given as soon as was reasonably possible. When BCBSNM receives a request for a Claim form or the notice of a Claim, BCBSNM will give the Member the Claim forms that we use for filing proof of loss. If the claimant does not receive these forms within 15 days after BCBSNM receives notice of Claim or the request for a Claim form, the claimant will be considered to meet the proof of loss requirements of this Plan if the claimant submits written proof of loss within 365 days after the date of the first service, except in the absence of legal capacity.

IF YOU HAVE OTHER VALID COVERAGE

When you have Other Valid Coverage that is "primary" over this Plan, you need to file your Claim with the other coverage first. (See *Section 7: Coordination of Benefits (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" later in this section.

If the Other Valid 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 Nonparticipating 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 Provider contract and another Participating Provider contract. Some Providers have **only** the Participating Provider contract and are **not** considered Preferred Providers. However, all Participating and Preferred Providers 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 contracting directly with BCBSNM) also have specific timely filing limits in their contracts with BCBSNM (usually 180 days). The Providers' contract language lets them know that they may not bill the employer or any Member for a service if the Provider does not meet the filing limit for that service and the Claim for that service is denied due to timely filing limitations.

NONPARTICIPATING PROVIDERS

A Nonparticipating Provider is one that has neither a Preferred or 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 Valid Coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the Claim form using the instructions on the form. (See special Claim filing instructions for out-of-country Claims under "Where to Send Claim Forms" later in this section.)

Payment normally is made to the Provider. However, if you have already paid the Provider for the services being claimed, your Claim must include evidence that the charges were paid in full. Upon approval of the Claim, BCBSNM will reimburse you for Covered Services, based on Covered Charges, less any required Member Copayment. You will be responsible for charges not covered by the Plan.

Please contact the Nonparticipating Provider for any balance billing issues. If you need additional assistance you may also contact the Managed Health Care Bureau (MHCB) at OSI.

Office of Superintendent of Insurance – MHCB

P.O. Box 1689

1120 Paseo de Peralta

Santa Fe, NM 87504-1689

1-(505) 827-4601 or toll free at 1-(855) 427-5674

Fax: (505) 827-6341, Attn: MHCB

Email: mhcb.grievance@state.nm.us

ITEMIZED BILLS

Claims for Covered Service must be itemized on the Provider's billing forms or letterhead stationery and must show:

- Members identification number
- Members and Subscriber's name and address
- Members date of birth and relationship to the Subscriber
- name, address, National Provider Identification number (NPI), and tax ID or social security number of the Provider
- 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)
- amount paid by you (if any) along with a receipt, cancelled check, or other proof of payment

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 to the Provider.

Do not file for the same service twice unless asked to do so by a Customer Service Advocate. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting. (See “Where to Send Claim Forms” below, for special instructions regarding out-of-country Claims.)

WHERE TO SEND CLAIM FORMS

If your Nonparticipating Provider does not file a Claim for you, you (not the Provider) are responsible for filing the Claim. **Remember:** Participating and Preferred Providers will file Claims for you; these procedures are used only when you must file your own Claim.

Services in United States, Canada, Jamaica, U.S. Virgin Islands, and Puerto Rico

If a Nonparticipating Provider will not file a Claim for you, ask for an itemized bill and complete a Claim form the same way that you would for services received from any other Nonparticipating Provider. Mail the Claim forms and

itemized bills to BCBSNM at the address below (or, if you prefer, you may send to the local Blue Cross Blue Shield Plan in the state where the services were received):

Blue Cross and Blue Shield of New Mexico
P.O. Box 660058
Dallas, TX 75266-0058

Mental Disorder/Chemical Dependency Claims

Claims for covered Mental Disorder and Chemical Dependency services received in New Mexico should be submitted to:

BCBSNM, BH Unit
P.O. Box 660058
Dallas, TX 75266-0058

Drug Plan Claims

If you purchase a Prescription Drug or other item covered under the drug plan from a Nonparticipating Pharmacy or Other Provider in an Emergency, or if you do not have your ID Card with you when purchasing a prescription or other covered item, you must pay for the prescription in full and then submit a Claim to APS pharmacy benefit manager. **Do not send these Claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must include the pharmacy name and address, drug name, prescription number, and amount charged. If not included in your enrollment materials, you can obtain the name and address of the pharmacy benefit manager from the APS Employee Benefits Department.

Services Outside the United States, U.S. Virgin Islands, Jamaica, and Puerto Rico

For covered inpatient Hospital services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands), show your Plan ID Card issued by BCBSNM. BCBSNM participates in a Claim 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.

You will need to pay up front for care received from a **Doctor,** a **Participating Outpatient Hospital,** and/or a **Nonparticipating Hospital.** Then, complete an *International Claim Form* and send it with the bill(s) to the service center (the address is on the form). The *International Claim Form* is available from BCBSNM, the service center, or on-line at:

www.bcbsglobalcore.com

The Blue Cross Blue Shield Global Core *International Claim Form* is to be used to submit institutional and professional Claims for benefits for covered Emergency services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. For filing instructions for other Claim types (e.g., dental, Prescription Drugs, etc.) contact the APS Employee Benefits Department. The *International Claim Form* must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the Claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The Member should submit an *International Claim Form* (available at www.bcbs.com), attach itemized bills, and mail to Blue Cross Blue Shield Global Core at the address below. Blue Cross Blue Shield Global Core will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the Claim. Once the Claim is finalized, the *Explanation of Benefits* will be mailed to the Subscriber and payment, if applicable, will be made to the Subscriber via wire transfer or check. Mail international Claims to:

Service Center
P.O. Box 2048
Southeastern, PA 19399

CLAIMS PAYMENT PROVISIONS

Most Claims will be evaluated and you and/or the Provider notified of the BCBSNM benefit decision within 30 days of receiving the Claim. If all information needed to process the Claim has been submitted, but BCBSNM cannot make a determination within 30 days, you will be notified (before the expiration of the 30-day period) that an additional 15 days is needed for Claim determination.

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 an Eligible Child of divorced parents, and the Subscriber under this Plan is the noncustodial parent, the custodial parent may receive the payment and the EOB.

If A Claim or Prior Authorization Is Denied

If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial. **You also have 180 days in which to appeal a decision.**

Covered Charge

Provider payments are based upon Preferred Provider and Participating 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 (e.g., for out-of-state Providers that contract with their local Blue Cross and Blue Shield Plan, the Covered Charge may be based upon the amount negotiated by the other Plan with its own Contracted Providers). You are responsible for paying Copayments, Deductibles, Coinsurance, and non-Covered 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.

Participating and Preferred Providers

Payments for Covered Services usually are sent directly to network (Preferred or Participating) Providers. The EOB you receive explains the payment.

Nonparticipating Providers

If Covered Services are received from a Nonparticipating Provider, payments are usually 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 penalty amounts, and non-Covered expenses.

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 judgment obtained by you when the Facility has not been paid its total billed charges from all other sources.

Assignment of Benefits

BCBSNM specifically reserves the right to pay the Subscriber directly and to refuse to honor an assignment of benefits in any circumstances. No person may execute any power of attorney to interfere with BCBSNM's right to pay the Subscriber instead of anyone else.

Medicaid

Payment of benefits for Members eligible for Medicaid is made to the appropriate state agency or to the Provider when required by law.

Medicare

If you are 65 years of age or older, BCBSNM will suspend your Claims until it receives (a) an *Explanation of Medicare Benefits (EOMB)* for each Claim (if you are entitled to Medicare), or (b) Social Security Administration documentation showing that you are not entitled to Medicare.

Overpayments

If your Group's benefit plan or the Claim Administrator pays benefits for Covered Charges incurred by you or your Eligible Family Members and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your Group's benefit plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Nonparticipating Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield of New Mexico (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different Member; or

b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Contracted Provider; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured Group benefit plan or individual policy, if the future benefit payment owed is to a Contracted Provider; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future payment owed to one or more Contracted Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's payment to a Contracted Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Contracted Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

INTER-PLAN ARRANGEMENTS

Blue Cross and Blue Shield of New Mexico (BCBSNM) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you obtain Health Care Services outside of the BCBSNM Service Area, the Claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the BCBSNM Service Area, you will receive it from one of two kinds of healthcare Providers. Most Providers ("Contracted Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Non-Contracted Providers do not contract with the Host Blue. BCBSNM how we pay both types of Providers.

BCBSNM covers only limited healthcare services received outside of the Service Area. As used in this section, "Out-of-Area Covered Services" for EPO plans refers to Emergency Care obtained outside the geographic area of the BCBSNM Service Area. Any other services will not be covered when processing through any Inter-Plan Arrangements, unless authorized by **your** Primary Care Provider ("PCP") or BCBSNM.

Inter-Plan Arrangements link the BCBSNM Provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to Contracted Providers. When you receive care outside of the BCBSNM Service Area, you will receive it from one of two types of Providers. Most Providers have a contractual agreement (i.e., are "Contracted Providers") with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Contracted Providers") don't contract with the Host Blue. BCBSNM explains below how BCBSNM pays both kinds of Providers. When services are received by you outside of the State of New Mexico for either Contracted or Non-Contracted Providers, the Host Blue will provide BCBSNM with a

Covered Charge based on what it uses for its own local Members for services received from either Contracted or Non-Contracted Providers in the state where the Host Blue is located.

For purposes of the Inter-Plan Arrangements described in this section, “Covered Charge" means the amount that BCBSNM determines is fair and reasonable for a particular covered and Medically Necessary service, as provided to BCBSNM by a Host Blue. After the Members share of the Covered Charge is calculated, BCBSNM will pay the remaining amount of the Covered Charge up to the maximum benefit limitation, if any.

BLUECARD® PROGRAM

Services Received from Contracted Providers Outside of New Mexico

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSNM will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Contracted Providers.

For inpatient Facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the Member will be held harmless for the Provider sanction.

Whenever you access Covered Services outside the BCBSNM service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is based on the lower of:

- The billed charges for your Covered Services; or
- The negotiated price or “allowable amount" that the Host Blue makes available to BCBSNM.

If the services are provided by a Contracted Provider of the Host Blue, the Provider will submit your Claims directly to the Host Blue to determine the allowable amount. BCBSNM will use the allowable amount to determine the Covered Charge so that your Claim can be processed timely. The Covered Charge will be an amount up to but not in excess of the allowable amount the Host Blue has passed on to BCBSNM. Because the services were provided by a Contracted Provider, you will receive the benefit of the payment/rate negotiated by the Host Blue with the Provider. As always, you will be responsible for any applicable Deductible, Copay and/or Coinsurance amounts (“Member Share"). The amount that BCBSNM pays together with your Member Share is the total amount the Contracted Provider has contractually agreed to accept as payment in full for the services you have received.

Often, this “allowable amount" will be a simple discount that reflects an actual price that the Host Blue pays to your Health Care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Health Care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Health Care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of past pricing of Claims as noted above. However, such adjustments will not affect the price we use for your Claim because they will not be applied after a Claim has already been paid.

In some cases, BCBSNM may, but is not required to, in its sole discretion, negotiate a payment with a Non-Contracting Health Care Provider on an exception basis. Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your liability calculation.

Services Received from a Non-Contracted Provider Outside of New Mexico
“Out-of-Area Covered Services” for EPO plans refers to Emergency Care obtained outside the geographic area of the BCBSNM Service Area. Any other services will not be covered when processing through any Inter-Plan Arrangements, unless authorized by BCBSNM.

INTER-PLAN ARRANGEMENTS: FEDERAL/STATE TAXES/SURCHARGES/FEES

Federal or state laws or regulations may impose a surcharge, tax, or other fee. If applicable, BCBSNM will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

SPECIAL CASES: VALUE-BASED PROGRAMS

If you received Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBNSM through average pricing or fee schedule adjustments. Additional information available upon request.

BLUE CROSS BLUE SHIELD GLOBAL CORE

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and Professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a Doctor or Hospital) outside the BlueCard Service Area, you should call the service center at 1-800-810-BLUE (2583), or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the Covered Charge.

Emergency Care Services

This Plan covers only limited Health Care Services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency services and Urgent Care obtained outside of the United States. Follow-up care following an Emergency is also available provided the services are approved through Prior Authorization by BCBSNM. Any other services will not be eligible for Benefits unless Prior Authorization is received from BCBSNM.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient Services, except for your cost-share amounts (Deductibles, Coinsurance, etc.). In such cases, the Hospital will submit our Claims to the service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. You must contact BCBSNM to obtain Prior Authorization for non-Emergency Inpatient Services.

- **Outpatient Services**

  Outpatient services are available for Emergency Care treatment. Physicians, Urgent Care centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard Service Area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claim processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from BCBSNM, the service center, or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.

MEMBER DATA SHARE

You may, under certain circumstances as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by BCBSNM, a division of Health Care Service Corporation, or, if you do not reside in the BCBSNM service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various ways, such as from involuntary termination of your health coverage sponsored by the Subscriber. As part of the overall plan of benefits that BCBSNM offers to you if you do not reside in the BCBSNM service area, BCBSNM may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this, BCBSNM may (1) communicate directly with you and/or (2) provide the

Host Blues whose service area covers the geographic area in which you reside with your personal information and may also provide other general information relating to your coverage under the Plan the Subscriber has with BCBSNM to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

COMPLAINTS AND APPEALS; SUMMARY OF PROCEDURES

If you want to make an oral complaint or file a written appeal about a Claims payment or denial, a Prior Authorization denial, the termination of your coverage (other than due to nonpayment of premium), or any other issue, a BCBSNM Customer Service Advocate is available to assist you. You will not be subject to retaliatory action by BCBSNM for making a complaint or filing an appeal.

IMPORTANT: Within 180 days after you receive notice of a BCBSNM decision on, for example, a Claim, a Prior Authorization request, the quality of care you receive, or the termination of your coverage, call or write BCBSNM Customer Service and explain your reasons for disagreeing with the decision. If you do not submit the request for internal review within the 180-day period, you waive your right to internal review as described in this section, unless you can satisfy BCBSNM that matters beyond your control prevented you from timely filing request.

Many complaints or problems can be handled informally by calling, writing, or e-mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can request internal review as described in the detailed *Appendix B: Notice - Inquiries/Complaints and Internal/External Appeals for Self-Funded Plans* notice applicable to your health plan which is included in the back of this booklet.

BCBSNM Contacts for Appeals

An appeal is an oral or written request for review of an "adverse benefit determination" or an adverse action by BCBSNM, its employees, or a Participating (in-network) Provider. To file an appeal or for more information about appeals, contact:

BCBSNM Appeals Unit

P.O. Box 660058

Dallas, TX 75266-0058

Telephone (toll-free): (800) 205-9926

e-mail: See Website at www.bcbsnm.com

Fax: (505) 816-3837

External Actions

Please refer to the Appendix B: Notice - Inquires/Complaints and Internal/External Appeals for Self-Funded Plans.

SECTION 9: 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.

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 Authorization for services on a timely basis. If due to circumstances not within the control of BCBSNM or a Network Provider (such as partial or complete destruction of facilities, war, riot, disability of a Network Provider, or similar case), BCBSNM and the Provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and its Network Providers will, however, make a good-faith effort to provide services.

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. See the inside back cover for further information.

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.

Nothing in this Benefit Booklet is intended to limit, restrict, or waive any Member rights under the law and all such rights are reserved to the individual.

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 Eligible Family Members 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 Network 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 Network 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 Network 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 Group.

MEMBER RIGHTS

All Members 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 a week, or urgent or Emergency Care services, and for other health services as defined by your Benefit Booklet.
- The right to receive information about BCBSNM, our services, practitioners and Providers and Member rights and responsibility.

- The right to participate with practitioners in making decisions about your health care.
- The right to make recommendations regarding BCBSNM's Member rights and responsibility policy.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its Health Care Providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, Providers, and appeals procedures and other information about the company and the benefits provided.
- 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 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 able, and documented in your medical record.
- 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 Authorization 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 and the right to a secondary appeal.

MEMBER RESPONSIBILITIES

As a Member enrolled in a Managed 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.

MEMBERSHIP RECORDS

BCBSNM will keep membership records and the employer will periodically forward information to BCBSNM to administer the benefits of this Plan. You can inspect all records concerning your membership in this Plan during normal business hours given reasonable advance notice.

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.

TRANSFER OF BENEFITS

All documents described in this booklet are personal to the Member. Neither these benefits nor health care plan payments may be transferred or given to any person, corporation, or entity. Any attempted transfer will be void. Use of benefits by anyone other than a Member will be considered fraud or material misrepresentation in the use of services or facilities, which may result in cancellation of coverage for the Member and appropriate legal action by BCBSNM and/or **Albuquerque Public Schools**.

SECTION 10: DEFINITIONS

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.

Adjustment Factor — The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the "Non-Contracting Allowable Amount." (See definition of "Covered Charge.") Adjustment Factors will be evaluated and updated no less than every two years.

Administrative Services Agreement — A contract for Health Care Services which by its terms limits eligibility to Members of a specified Group. The Administrative Services Agreement includes the Benefit Program Application and may include coverage for family members.

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.)

Adverse Determination — A decision made either pre-service or post-service by BCBSNM that a Health Care Service requested by a Provider or Member has been reviewed and based upon the information available does not meet the requirements for coverage or Medical Necessity and the requested Health Care Service is either denied, reduced, or terminated.

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

Alcohol Abuse Treatment Facility, Alcohol Abuse Treatment Program — An appropriately licensed Provider of Medical Detoxification and rehabilitation treatment for Alcohol Abuse.

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.

Applied Behavioral Analysis (ABA) — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal

of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, "maladaptive" behaviors.

Autism Spectrum Disorder (ASD) — A condition that meets the diagnostic criteria for Autism Spectrum Disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American psychiatric association; or a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative disorder pursuant to diagnostic criteria published in a previous edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American psychiatric association.

Benefit Booklet — This document or evidence of coverage issued to you along with the *Plan Highlights*, and in conjunction with the APS Employee Benefits Enrollment Guide, explain the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Benefit Program Application (BPA) — The application for coverage completed by **Albuquerque Public Schools**.

Biomarker Testing —The analysis of tissue blood, or other biospecimen for the presence of biomarker, including single-analyte tests, multi-plex panel tests. Protein expression and whole exome, whole genome, and whole transcriptome sequencing.

Blue Access for Members (BAM) — On-line programs and tools that BCBSNM offers its Members to help track Claims payments, make health care choices, and reduce health care costs. For details, see *Section 1: How To Use This Benefit Booklet.*

BlueCard — BlueCard is a national program that enables Members of one Blue company to obtain Health Care Services while traveling or living in another Blue company's service area. The program links Participating Health Care Providers with the independent Blue companies across the country and in more than 200 countries and territories worldwide, through a single electronic network for Claims processing and reimbursement.

BlueCard Access — The term used by Blue Cross and Blue Shield companies for national Doctor and Hospital finder resources available through the Blue Cross and Blue Shield Association. These Provider location tools are useful when you need covered health care outside New Mexico. Call BlueCard Access at 1 (800) 810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder at www.bcbsnm.com.

Blue Cross and Blue Shield of New Mexico — A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association; also referred to as BCBSNM.

Calendar Year — A Calendar Year (also known as a benefit period) is a period of one year that begins on January 1 and ends on December 31 of the same year. The initial Calendar Year benefit period is from a Members Effective Date of Coverage and ends on December 31, which may be less than 12 months.

Cancer Clinical Trial — A course of treatment provided to a patient for the prevention of reoccurrence, early detection or treatment of cancer for which standard cancer treatment has not been effective or does not exist. It does not include trials designed to test toxicity or disease pathophysiology, but must have a therapeutic intent and be provided as part of a study being conducted in a Cancer Clinical Trial in New Mexico. The scientific study must have been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects and include all of the following: specific goals, a rationale and background for the study, criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions, and a reasonable expectation based on clinical or pre-clinical data, that the treatment will be at least as effective as standard cancer treatment. The trial must have been approved by a United States federal agency or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

Cardiac Rehabilitation — An individualized, supervised physical reconditioning exercise session lasting 4-12 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.

Cessation Counseling — As applied to the "smoking/tobacco use cessation" benefit described in *Section 5: Covered Services*, under "Preventive Services," Cessation Counseling means a program, including individual, Group, or proactive telephone quit line, that:

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information, and follow-up;
- operates under a written program outline that meets minimum requirements established by the Office of Superintendent of Insurance;
- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

Chemical Dependency — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of Alcohol, drugs or other substance. Chemical Dependency (also referred to as "substance abuse," which includes Alcohol or Drug Abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of Alcohol, drugs, or other substance is discontinued.

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

Child — See definition of "Eligible Family Members" in *Section 2: Enrollment and Termination Information.*

Chiropractor 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.

Claim — The term "Claim," as used in this document, refers only to post-service bills for services already received and sent to BCBSNM (or its designee) for benefit determination.

Claims Administrator — Blue Cross and Blue Shield of New Mexico (BCBSNM) which is the entity providing consulting services in connection with the operation of this benefit plan, including the processing and payment of Claims and other such functions as agreed to from time to time by your Group and BCBSNM.

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 — A percentage of Covered Charges that you are required to pay for a Covered Service. For Covered Services that are subject to Coinsurance, you pay the percentage (indicated on the *Plan Highlights*) of BCBSNM's Covered Charge after the Deductible (if any) has been met.

Contracted Provider — A Provider that has a contract with BCBSNM or another BCBS Plan to bill BCBSNM (or other BCBS Plan) directly and to accept this health plan's payment (provided in accordance with the provisions of the

contract) plus the Members share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services. Also see "Network Provider (In-Network Provider)," in this section.

Copayment — The fixed-dollar amount (or, in some cases, a percentage) that you must pay to a Health Care Provider upfront in order to receive a specific service or benefit covered under this Plan. Copayments are listed on the *Plan Highlights.*

Cosmetic Surgery Services — Cosmetic Surgery Services is a beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of physical characteristics.

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 — The amount that the Plan determines is a fair and reasonable allowance for a particular Covered Service. After your share of a covered charge (e.g., Deductible, copayment, Coinsurance, and/or penalty amount) has been calculated, the Plan 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.** Also see "Claims Payment Provision" in *Section 8: Claims Payments and Appeals*. Your choice of Provider will determine if you will also have to pay the difference between the covered charge and the billed charge.

Covered Charge — The amount that BCBSNM allows for Covered Services using a variety of pricing methods and based on generally accepted Claim coding rules. The Covered Charge for services from "Contracted Providers" is the amount the Provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan. For information about pricing of Non-Contracted Provider Claims, see "Pricing of Non-Contracted Provider Claims" in *Section 8: Claims Payments and Appeals*.

> **Non-Contracting Allowable Amount** — The maximum amount, not to exceed billed charges, that will be allowed for a Covered Service received from a Non-Contracted Provider in most cases. The BCBSNM Non-Contracting Allowable Amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).
>
> **Medicare Allowable** — The amount allowed by CMS for Medicare-Participating Provider services, which is also used as a base for calculating Non-Contracted Provider Claims payments for some Covered Services of Non-Contracted Providers under this health plan. The Medicare Allowable amount will not include any additional payments that are not directly tied to a specific Claim, for example, medical education payments. If Medicare is primary over this health plan, and has paid for a service, the Covered Charge under this health plan may be one of the two following amounts:
>
> **Medicare-approved Amount** — The Medicare fee schedule amount upon which Medicare bases its payments. When Medicare is the primary carrier, it is the amount used to calculate secondary benefits under this health plan when no "Medicare Limiting Charge" is available. The Medicare-approved amount may be less than the billed charge.
>
> **Medicare Limiting Charge** — As determined by Medicare, the limit on the amount that a Nonparticipating Provider can charge a Medicare beneficiary for some services. When Medicare is the primary carrier and a limiting charge has been calculated by Medicare, this is the amount used to determine your secondary benefits under this health plan. **Note:** Not all Medicare-Covered Services from Nonparticipating Providers are restricted by a Medicare Limiting Charge.

Covered Services — Those services and other items for which benefits are available under the terms of the benefit plan of an Eligible Plan Member.

Creditable Coverage — Health care coverage through an employment-based Group Health Care 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.

Custodial Care Services — Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.), and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Cytological Screening — A papanicolaou test or liquid-based cervical cytopathology, a human papillomavirus test, and a pelvic exam for symptomatic, as well as, asymptomatic female patients.

Deductible — The amount of Covered Charges that you must pay in a Calendar Year before this Plan begins to pay its share of Covered Charges you incur during the same benefit period. If the Deductible amount remains the same during the Calendar Year, you pay it only once each Calendar Year and it applies to all Covered Services you receive during that Calendar Year.

Dental-Related Services — Services performed for treatment or 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.

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 non-alcoholic substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug Abuse does not include nicotine addiction or Alcohol Abuse.

Drug Abuse Treatment Facility— An appropriately licensed Provider primarily engaged in detoxification and rehabilitation treatment for Chemical Dependency.

Drug Plan Summary of Benefits — The separately issued document that explains the coverage available to you for prescription drugs, insulin, diabetic supplies, and certain nutritional products. (This document is issued by the APS pharmacy benefit manager.)

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 Members coverage under this Plan begins.

Eligible Family Members — See "Eligible Family Members" in *Section 2: Enrollment and Termination Information* for more information about Eligible Family Members.

Emergency, Emergency Care — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical, Mental Disorder, or Chemical Dependency 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. In addition, services must be received in an Emergency room, trauma center, or Ambulance to qualify as an Emergency. Examples of Emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Enteral Nutritional Products — A product designed to provide calories, protein, and essential micronutrients by the enteral route (i.e., by the gastrointestinal tract, which includes the stomach and small intestine only).

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

- a technology must have final approval from the appropriate regulatory government bodies; however, approval by a governmental or regulatory agency will be taken into consideration by BCBSNM in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative;
- the scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- the technology must improve the net health outcome;
- the technology must be as beneficial as any established alternatives; and
- the improvement must be attainable outside the Investigational settings.

Facility — A Hospital (see "Hospital" later in this section) or other institution (also, see "Provider" later in this section).

FDA — The United States Food and Drug Administration.

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.

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).

Group — Refers to Albuquerque Public Schools.

Group Health Care Plan — An employee welfare benefit plan as defined in Section 3(1) of the federal 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 Eligible Family Members (as defined under the terms of the Plan).

Habilitative Services — Occupational Therapy, Physical Therapy, Speech Therapy and other Health Care Services that help you keep, learn, or improve skills and functioning for daily living, as prescribed by your Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder. These pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Benefit Booklet.

Health Care Benefits — Benefits for Medically Necessary services consisting of preventive care, Emergency Care, inpatient and out-patient Hospital and Physician care, diagnostic laboratory and diagnostic and therapeutic radiological services and does not include dental services, vision services for adults, or long-term rehabilitation treatment.

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 Residential Treatment Center, a Home Health Care Agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

Home Health Care Agency — An appropriately licensed Provider that both:

- brings Skilled Nursing Care 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.

Home Health Care Services — Covered Services, as listed under "Home Health Care/Home I.V. Services" in *Section 5: Covered Services,* 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.

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 Members 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 Patients 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 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 Care 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.)

Host Blue — When you are outside New Mexico and receive Covered Services, the Provider will submit Claims to the Blue Cross Blue Shield (BCBS) Plan in that state. That BCBS Plan (the "Host Blue" Plan) will then price the Claim according to local practice and contracting, if applicable, and then forward the Claim electronically to BCBSNM - your "Home" Plan - for completion of processing (e.g., benefits and eligibility determination). For details, see "BlueCard" in *Section 8: Claims Payments and Appeals.*

Identification Card (ID Card) — The Card BCBSNM issues to the Subscriber that identifies the cardholder as a Plan Member.

Initial Enrollment Date — A Member's Effective Date of Coverage. For a Late Applicant or for a person applying under a Special Enrollment provision, the Initial Enrollment Date is his/her Effective Date of Coverage.

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 5-12 hours of continuous Mental Disorder or Chemical Dependency care during any 24-hour period in a treatment Facility).

Intensive Outpatient Program (IOP) — Distinct levels or phases of treatment that are provided by a certified/licensed Chemical Dependency or Mental Disorder program. IOPs provide a combination of individual, family, and/or Group therapy in a day, totaling nine or more hours in a week.

Investigational Drug or Device — For purposes of the "Cancer Clinical Trial" benefit described in *Section 5: Covered Services* under "Rehabilitation and Other Therapy," an "Investigational Drug or Device" means a drug or device that has not been approved by the federal Food and Drug Administration.

Involuntary Loss of Coverage — As applied to Special Enrollment provisions, loss of other coverage due to legal separation, divorce, death, moving out of a 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 Good Cause.

Late Applicant — Unless eligible for a Special Enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 60 days** of becoming eligible for coverage under this health care plan (e.g., a child added **more than 60 days** after birth or legal adoption, a new spouse or stepchild added more than 60 days after marriage)
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

Licensed Midwife — A person who practices lay midwifery and is registered as a Licensed Midwife by the New Mexico Department of Health (or appropriate state regulatory body).

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.

Managed Health Care Plans — A "Managed Health Care Plan" is a health plan that requires a Member to use, or encourages a Member to use, a "Network" Provider (your Provider network is determined by the type of health plan you have). Your health plan may require you to use Network Providers in order to receive benefits. Your health plan may provide a higher level of benefit for in-network services. Therefore, your choice of Provider under a Managed Health Care Plan determines the amount and kind of **benefits** you receive under your health care plan. **Your BCBSNM health plan does not prevent you from choosing to receive services from a Provider outside the network.** The choice of Provider is still up to you - but the health plan is not obligated to provide benefits for every service you seek to receive. You may receive no benefits for services received outside the network. Check *Section 3: How Your Plan Works* and your *Plan Highlights* to find out what your benefits are in-network and Out-of-Network.

Maternity/Pregnancy-Related — 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 C-section. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* 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 in an acute care Facility for withdrawal from the physiological effects of Alcohol or Drug Abuse. (Detoxification usually takes about three days in an acute care Facility.)

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 Accidental Injury.

Medically Necessary, Medical Necessity — 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, Mental Disorder or Chemical Dependency condition, illness, or disease.

Medicare — The program of health care for the aged, End-Stage Renal Disease (ESRD) patients and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Member — An enrollee (the Subscriber or any Eligible Family Member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Administrative Service Agreement. Throughout this Benefit Booklet, the terms "you" and "your" refer to each Member.

Mental Disorder — 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 Disorder does not include developmental disabilities, Autism or Autism Spectrum Disorders, drug or Alcohol Abuse, or learning disabilities.

Morbid Obesity — A serious health condition that can interfere with a person's basic physical functions such as breathing or walking and that meets the following criteria with respect to such person's weight and/or health:

- a body mass index (BMI) equal to or greater than 40 kg/meters^2;
- a BMI equal to or greater than 35kg/meters^2 with at least one (1) of the following clinically significant -related diseases or complications that are not controlled by best practice medical management: hypertension, dyslipidemia, diabetes mellitus, coronary heart disease, sleep apnea, or osteoarthritis.

Network Provider (In-Network Provider) — A Contracted Provider that has agreed to provide services to Members in your *specific* type of health plan (e.g., PPO, EPO, etc.).

Non-Contracted Provider — A Provider that does not have any contract with BCBSNM, either directly or indirectly (for example, through another BCBS Plan), to accept the Covered Charge as payment in full under your health plan.

Noncontracting Allowable Amount— See definition of "Covered charge" earlier in this section.

Nonparticipating Provider — An appropriately licensed Health Care Provider that has not Contracted directly or indirectly, for the service being provided, with BCBSNM. See the *Plan Highlights* for those services that are not covered if received from a Nonpreferred Provider (all Nonparticipating Providers are also Nonpreferred Providers).

Nonpreferred Provider — Providers that have not Contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These Providers may have "Participating-only" Provider agreements, but are **not** considered "Preferred" Providers and are **not** eligible for Preferred Provider coverage under your health plan -unless listed as an exception under "Benefit Level Exceptions" earlier in the booklet. **Note: See the *Plan Highlights* for those services that are not covered if received from a Nonpreferred Provider.**

Non-Contracting Allowable Amount— See definition of "Covered Charge" earlier in this section.

Obstetrician-Gynecologist — A Physician who is board-eligible or board-certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

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 semi-rigid 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.

OSI — The Office of Superintendent of Insurance.

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 will be considered Other Valid Coverage for purposes of coordinating benefits under this Plan.

Other Providers — 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 Chemical Dependency services, a Provider also includes a Licensed Alcohol and Drug Abuse Counselor (L.A.D.A.C.).

Out-of-Pocket Limit — The maximum amount of Deductible, Coinsurance, and/or Copayments that you pay for most Covered Services in a Calendar Year. After an Out-of-Pocket Limit is reached, this Plan pays **100 percent** of most of your Preferred Provider Covered Charges for the rest of that Calendar Year, not to exceed any benefit limits. The APS prescription drug plan has a separate out-of-pocket limit.

Outpatient Services — Medical/Surgical Services received in the outpatient department of a Hospital, observation room, Emergency room, Ambulatory Surgical Facility, freestanding Dialysis Facility, or other covered outpatient treatment Facility.

Outpatient Surgery — Any Surgical Services 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.

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 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.

Physician Assistant — A graduate of a Physician Assistant or Surgeon Assistant program approved by a nationally recognized accreditation body or a skilled person who is currently certified by the National Commission on Certification of Physician Assistants, who is licensed in the state of New Mexico (or by the appropriate state regulatory body) to practice medicine under the supervision of a licensed Physician.

Plan Highlights — The separately issued schedule that lists Copayments, Deductible, Member Coinsurance percentage amounts, Out-of-Pocket Limits, and annual or lifetime benefits, and provided an overview of the Member's medical plan benefits.

Podiatrist — A licensed Doctor of Podiatric Medicine (D.P.M.). A Podiatrist treats conditions of the feet.

Post Service Medical Necessity Review — A review, sometimes referred to as a retrospective review or Post-Service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

Predetermination — An optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

Preferred Provider — See definition of "Provider," below.

Pregnancy-Related Services — See definition of "Maternity," earlier in the section.

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

Primary Preferred Provider (PPP) — See definition of "Provider."

Prior Authorization — An advance confirmation to determine Medical Necessity, as may be required where permitted by law, for certain services to be eligible for benefits.

Probationary Period — The amount of time an employee must work before becoming eligible for any health care coverage offered by the employer sponsoring this plan. Your employer determines the length of the probationary period.

Professional Provider (Health Care Professional) — A Physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide Health Care Services consistent with state law.

Prosthetics 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 or other licensed Facility, Physician, or other Health Care Professional authorized to furnish Health Care Services within the scope of their license.

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:

> **PPP (Primary Preferred Provider):** A Preferred Provider in one of the following medical specialties: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; Oriental Medicine; or Pediatrics. PPPs do **not** include Physicians specializing in any other fields such as Obstetrics, Geriatrics, Pediatric Surgery or Pediatric Allergy.
>
> **Preferred Provider:** A Provider who has contracted with BCBSNM as a Preferred Provider but does not practice one of the Primary Preferred Provider medical specialties.
>
> **Nonpreferred Provider** — Providers that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These Providers may have "Participating-only" Provider agreements, but are **not** considered "Preferred" Providers and are **not** eligible for Preferred Provider coverage under your health plan -unless listed as an exception under "Benefit Level Exceptions" earlier in the booklet.
>
> **PPO Specialist:** A Practitioner of the Healing Arts who is in the Preferred Provider Network - but does not belong to one of the specialties defined above as being for a "Primary Preferred Provider" (or "PPP"). A

specialist does not include Hospitals or other treatment Facilities, Urgent Care Facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary Health Care Providers.

Network Provider agrees to provide Health Care Services to Members with an expectation of receiving payment 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.

Psychologist — A person who is duly licensed or certified in the state where the service is rendered and has a doctoral degree in psychology and has had at least two years of clinical experience in a recognized health setting or has met the standards of the national register of health service Providers in psychology.

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, telecobalt, 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 Lay Midwife — Any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

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.

Registered Nurse (R.N.) in an Expanded Practice — A person licensed by the board of nursing as a Registered Nurse for Expanded Practice as a Certified Nurse Practitioner, certified Registered Nurse anesthetist, certified clinical nurse specialist in psychiatric Mental Disorder nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing specialty and is certified by a national nursing organization.

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.
Rehabilitative Service — Including, but not limited to Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Physician that must be limited to therapy which is expected to result in significant improvement in the conditions for which it is rendered, “Rehabilitative Services” must be expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition.

Residential Treatment Center — A Facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patient served or to be served by such facility. Residential Treatment Center must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses, or other Facilities that provide primarily a supportive/custodial environment and/or primarily address long-term social needs, even if counseling is provided in such Facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing service care and supervision for at least one shift a day with on call availability for other shifts.

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, including alpha-fetoprotein IV screening
- routine medical care in the Hospital after delivery
- pediatrician
- services related to circumcision of a male newborn
- standby care at a C-section procedure

Routine patient Care cost — For purposes of the Cancer Clinical Trial benefit described under "Rehabilitation and Other Therapy" in *Section 5: Covered Services,* 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 supplier 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 Cancer 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 screening colonoscopy/mammogram — Tests to screen for occult colorectal and/or breast cancer in persons who, at the time of testing, are not known to have active cancer of the colon or breast, respectively. (If there is a history of colon or breast cancer, for the purposes of the "Preventive Services" benefit, a cancer is no longer active if there has been no treatment for it and no evidence of recurrence for the previous three years.) Routine screening tests are performed at defined intervals based on recommendations of national organizations as summarized in the BCBSNM Preventive Care Guidelines. Routine screening tests do not include tests (sometimes called "surveillance testing") intended to monitor the current status or progression of a cancer that is already diagnosed.

Routine screening mammography does **not** include "diagnostic mammography" which is a mammogram done after an 96 abnormal finding has first been detected, or screening the opposite breast when the other breast has cancer. Routine colonoscopy does not include colonoscopy done for follow-up of colon cancer. A colonoscopy is still considered screening if, during the colonoscopy, previously unknown polyps were removed. Colonoscopies performed to remove known polyps are not routine screening colonoscopies. Routine screening colonoscopy does not include upper endoscopy (esophagogastroduodenal endoscopy), sigmoidoscopy, or computerized tomographic colonography (sometimes referred to as "virtual colonoscopy").

Note: BCBSNM Preventive Care Guidelines may be found at the BCBSNM website:

www.bcbsnm.com/provider/clinical-resources/preventive-care-guidelines

Service Area — The geographic area where BCBSNM is licensed to conduct business (all counties in New Mexico).

Short-Term Rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and Speech Therapy techniques that are Medically Necessary to restore and improve lost bodily functions following illness or Accidental Injury. (This does not include services provided as part of an approved home health or Hospice Admission, which are subject to separate benefit limitations and exclusions, and does not include Alcohol or Drug Abuse rehabilitation.)

Skilled Nursing Care — Care that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse (L.P.N.) or Registered Nurse (R.N.).

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 tuberculosis or for intermediate Custodial or educational care.

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 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.")

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.

Special Enrollment — When an otherwise Eligible Employee or Eligible Family Member did not enroll in the Plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her Eligible Family Members, if any, may enroll in the Plan at a later date - or more than 60 days after becoming eligible - and not considered Late Applicants. The "Special Enrollment" period is the period of time during which an otherwise Late Applicant may apply for coverage outside the annual open enrollment period.

Special Medical Foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a Physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special Medical Foods are covered only when prescribed by a Physician for treatment of genetic orders of metabolism, and the Member is under the Physician's ongoing care. Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a healthy diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

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

Speech Therapy — Services used for the diagnosis and treatment of speech and language disorders.

Subscriber — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of an individual contract, the person in whose name the contract is issued. The term "Subscriber" may also encompass other persons in a nonemployee relationship with the employer, Group, or business if specified in the Administrative Services Agreement (e.g., COBRA Members).

Summary of Benefits and Coverage (SBC) — The separately issued schedule that defines your Copayment and/or Coinsurance requirements, Deductible, Out-of-Pocket Limit, and annual or lifetime benefits, and provides an overview of Covered Services.

Surgical Services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or Accidental 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.

Telemedicine — The use by a licensed health care professional, acting within the scope of their license, of interactive, simultaneous audio and video or store-and-forward technology using information and telecommunications technologies to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

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.

Terminally Ill Patient — A patient with a life expectancy of **six months or less**, as certified in writing by the attending Physician.

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.

Totally Disabled — A Member (Subscriber or Eligible Family Member) who is prevented, solely because of illness or Accidental Injury, from engaging in substantial gainful employment or is incapable of doing most of the normal tasks and activities for that person's age and family status. With respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a similarly situated person who is in good health.

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).

Virtual Visits — Consultation with a licensed Provider through interactive video and/or store-and-forward technology via online portal or mobile application.

Well-Child Care — Periodic health and development 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 and the U.S, Preventive Services Task Force (USPSTF).

APPENDIX A: 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 this 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 APS Employee Benefits Department to determine if you are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage;
- when it may become available to you and your family; and
- what you need to do to protect your right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the Plan and under federal law, contact the APS Employee Benefits Department.

Either the APS Employee Benefits Department or a third party named by the APS Employee Benefits Department is responsible for administering COBRA continuation coverage. Contact the APS Employee Benefits Department 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/Domestic Partners of employees, and Eligible Children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the APS Employee Benefits Department and/or COBRA administrator for specific information.

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 or Domestic Partner 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 or Domestic Partner dies;
- your spouse's/ Domestic Partner's hours of employment are reduced;
- your spouse's/ Domestic Partner's employment ends for any reason other than his or her gross misconduct;
- your spouse/Domestic Partner becomes enrolled in Medicare (Part A, Part B or both); or
- you become divorced or legally separated from your spouse.

Your Eligible Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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 an "Eligible Child".

The Plan will offer COBRA continuation coverage to qualified beneficiaries when the qualifying event is:

- the end of employment;
- the reduction of hours of employment;
- the death of the employee;
- an Eligible Child losing eligibility for coverage as an Eligible Child;
- 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 the enrollment of the employee in Medicare (Part A, Part B or both)) you must notify the Plan administrator. The Plan requires you to notify the Plan administrator **within 60 days** after the qualifying event occurs. Contact the APS Employee Benefits Department for procedures for this notice, including a description of any required information or documentation.

Once the APS Employee Benefits Department 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
- an Eligible Child losing eligibility as an Eligible 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 APS Employee Benefits Department or COBRA 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 the COBRA 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 the APS Employee Benefits Department 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/Domestic Partner and Eligible 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/Domestic Partner and Eligible 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 an Eligible Child when that child stops being eligible under the Plan as an Eligible Child.

In all of these cases, you must make sure that the COBRA administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact the APS Employee Benefits Department 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 APS Employee Benefits Department or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers 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 APS Employee Benefits Department 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 the APS Employee Benefits Department and/or the COBRA administrator.

PLAN CONTACT INFORMATION

Contact the APS Employee Benefits Department for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

APPENDIX B: NOTICE - INQUIRIES/COMPLAINTS AND INTERNAL/EXTERNAL APPEALS FOR SELF-FUNDED PLANS

This notice is made a part of APS's self-funded health care plan Benefit Booklet, administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). If you have a question about these procedures, please call a Customer Service Advocate at the phone number printed on the back of your Identification Card. NOTE: Whenever these procedures require that an action be taken by any party, including BCBSNM, within a certain period of time from receipt of a request or document, the request or document will be deemed to have been received within three working days of the date it was mailed.

Change in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

GENERAL INQUIRIES AND COMPLAINTS

Inquiry - A general request for information regarding Claims, benefits, or membership.

Complaint - An expression of dissatisfaction by you, either orally or in writing. Issues may include, but are not limited to, Claims payments or denials, quality of care, and locating a Network Provider.

The Claims Administrator, BCBSNM, has a team available to assist you with inquiries and complaints. To make an inquiry or complaint, contact a Customer Service Advocate at the phone number on the back of your ID Card or by mail at the address on the first page of this Benefit Booklet (inquiries about Mental Health services are directed to the Behavioral Health Unit; appeals are directed to the general BCBSNM Appeals Unit as indicated later in this appendix notice).

INITIAL INTERNAL REVIEW OF CLAIMS/PRIOR AUTHORIZATION REQUESTS

When you or your treating Health Care Professional requests a Prior Authorization under your Plan. If the requested service is not covered, BCBSNM will not review for Medical Necessity, but will send you notice that there is no coverage for the requested service.

Only if the requested service is possibly covered, will BCBSNM review for Medical Necessity. If the requested service is approved as Medically Necessary, you will receive notice of that determination. An approval does not ensure that the service will be covered. For example, if you are not eligible for coverage at the time services are received, if the service you receive is different from the service authorized, or if your benefit plan changes or terminates before you receive the service in question, the service may still be denied.

Prior Authorization - A decision by BCBSNM that a Health Care Service has been reviewed and, based upon the information available, meets BCBSNM's requirements for coverage and Medical Necessity.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

— ***Urgent Care Clinical Claim*** - Any pre-service Claim that requires Prior Authorization, as described in the Benefit Booklet, for a benefit determination for medical care or treatment for which the application of regular notification time periods could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of the Physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment.

— ***Post-service Claim*** - A notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

— ***Pre-service Claim*** - A request for Prior Authorization, which is any non-urgent request for a benefit or for a benefit determination for which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. A voluntary request for advance determination of benefits is not a pre-service request for purposes of this provision.

URGENT CARE CLINICAL CLAIMS*	
Type of Notice or Extension	**Timing**
If your Claim is incomplete, the Claims Administrator must notify you within:	**24 hours**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claims Administrator within:	**48 hours** after receiving notice
The Claims Administrator must notify you of the Claim determination (whether adverse or not):	
if the Claim is complete, as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claims Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

PRE-SERVICE CLAIMS	
Type of Notice or Extension	**Timing**
If your Claim is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your Claim is incomplete, the Claims Administrator must notify you within:	**15 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**15 days***
if the initial Claim is incomplete, within:	**30 days****
If you require post-stabilization care after an Emergency, within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

*This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

**If additional information is necessary to decide the Claim, the time period for making the decision is suspended from the day you are notified to the earlier of: (1) the date on which your response is received by BCBSNM; or (2) the date established by BCBSNM for the furnishing of the requested information (at least 45 days). The number of days shown above includes a 15 day extension.

POST-SERVICE CLAIMS	
Type of Notice or Extension	**Timing**
If your Claim is incomplete, the Claims Administrator must notify you within:	**30 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the Claim determination (whether adverse or not):	
if the Claim is complete, as soon as possible (taking into account medical exigencies), but no later than:	**30 days***
if the initial Claim is incomplete, within:	**45 days****

*This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

**If additional information is necessary to decide the Claim, the time period for making the decision is suspended from the day you are notified to the earlier of: (1) the date on which your response is received by BCBSNM; or (2) the date established by BCBSNM for the furnishing of the requested information (at least 45 days). The number of days shown above includes a 15 day extension.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

MANNER AND CONTENT OF CLAIM/PRIOR AUTHORIZATION DENIAL NOTICES

On occasion, the Claim Administrator may deny all or part of your Claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision as described in Internal Appeal Procedures below.

If your Prior Authorization request or Claim is denied in whole or in part, you will be notified in writing or by electronic means, within the time frames stated above, of the following:

- subject to privacy laws and other restrictions, if any, the identification of the Claim, the date of service, Health Care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for determination;
- a reference to the specific health plan provision(s) on which the denial is based, or the contractual, administrative or protocol for the determination;
- the specific internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, if the denial was based on Medical Necessity, experimental treatment, or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- a description of additional information that may be needed to perfect the request or Claim and an explanation of why such material is needed;

- a description of BCBSNM's internal review/appeals and external review procedures and time limits (and how to initiate a review/appeal or external review) including a statement of your right, if any, to pursue any state and, if applicable, federal legal remedies, following a final denial on internal review/appeal;
- in certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- the right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claim for benefits;
- in the case of a denial of an Urgent Care Clinical Claim, a description of the expedited internal review procedure applicable to such Claims (an Urgent Care Claim decision may be provided orally, so long as written notice is furnished to you within three days of oral notification);
- contact information for applicable office of health insurance consumer assistance or ombudsman.

IMPORTANT: For *Adverse Benefit Determinations* that are related to any Claim or Prior Authorization denial, reduction, termination, or failure to provide or make payment that is based on a **determination of eligibility** to participate in the Plan, including contributions for coverage, you must contact the APS **Employee Benefits Department**.

INTERNAL APPEAL PROCEDURES

The following definitions apply to the Claims Administrator's internal appeal procedures (i.e., for issues not related to eligibility determinations):

Adverse Benefit Determination - A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment for a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator and the Claims Administrator reduces or terminates such treatment (other than by amendment or termination of the employer's benefit plan) before the end of the approved treatment period; that is also an *Adverse Benefit Determination*. A rescission of coverage is also an *Adverse Benefit Determination*. (A rescission of coverage does not include a termination of coverage for reasons related to nonpayment of premium.) In addition, an *Adverse Benefit Determination* also includes an Adverse Determination. For purposes of this Plan, BCBSNM will refer to both an "Adverse Determination" and an "Adverse Benefit Determination" as an "Adverse Benefit Determination," unless indicated otherwise.

Appeal - An oral or written request for review of an *Adverse Benefit Determination* or an adverse action by the Claims Administrator ("BCBSNM"), its employees, or a Participating Provider.

Final Internal Adverse Benefit Determination - An *Adverse Benefit Determination* that has been upheld at the completion of BCBSNM's internal appeal process or with respect to which the internal appeals process has been deemed exhausted.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to Health Care Services, including but not limited to, procedures or treatments ordered by a Health Care Provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claims Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claims Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claims

Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claims Administrator.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a Claim, any determination of a request for Prior Authorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an *Adverse Benefit Determination* may be filed by you or a person authorized to act on your behalf. For an Urgent Care Clinical Claim, a Health Care Provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID Card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an *Adverse Benefit Determination*, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the *Adverse Benefit Determination*. You may contact the Claim Administrator at:

BCBSNM Appeals Unit
P.O. Box 660058
Dallas, TX 75266-0058
Telephone (toll-free): (800) 205-9926

- In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial *Adverse Benefit Determination*. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond before the final determination is made. If the information is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the time periods for providing notice will be tolled until such time as you have had a reasonable opportunity to respond. After you respond or have had a reasonable opportunity to respond but have failed to do so, the Claim Administrator will notify you of the determination in a reasonably prompt time, taking into account the medical exigencies. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your Claim. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal determination will be made by a Physician associated or Contracted with us and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

For non-eligibility issues, you or your authorized representative may request an appeal of a Claims or Prior Authorization decision, orally or in writing, by contacting:

BCBSNM Appeals Unit
P.O. Box 660058
Dallas, TX 75266-0058
Telephone (toll-free): (800) 205-9926
FAX: (505) 816-3837

Time-frame for Completion of Internal Appeal

Upon receipt of a non-urgent pre-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

You have the right to request a postponement of the appeal review process by submitting your request in writing.

Manner and Content of Notification of Internal Appeal Decision

BCBSNM will provide you with written or electronic notice of the Internal Appeal Decision within the time-frames described above. You have the right to request, free of charge, reasonable access to and copies of all documents, records, and other information related to your appeal. If your appeal is denied in whole or in part, you will be notified in writing of the following:

- subject to privacy laws and other restrictions, if any, the identification of the Claim, the date of service, Health Care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for the determination;
- the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
- any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- a description of the standard that was used in denying the Claim and a discussion of the decision;
- a description of BCBSNM's internal review procedures and time limits including your right to pursue an external action following a final Adverse Determination on internal appeal and the timeframe within which such action must be filed;
- in certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claims Administrator’s decision is to continue to deny or partially deny your Claim or Prior Authorization request or if applicable you do not receive a timely decision, you may be able to request an external review of your Claim or Prior Authorization request by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the next section.

INDEPENDENT EXTERNAL REVIEW

For non-eligibility issues, you or your authorized representative may make a request for a standard external review or expedited external review of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* by an independent review organization (IRO). External review is available for an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that involves medical judgment (including, but not limited to, those based on requirements, for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is Experimental or Investigational), as determined by the external reviewer. Rescission's are also eligible for external review.

1. Request for external review. Within four months after the date of receipt of a notice of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* from BCBSNM, you or your authorized representative must file your request for standard external review.

2. Preliminary review. Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- The *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
- You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the “Exhaustion” section below for additional information about the exhaustion of the internal appeal process; and
- You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within one business day after BCBSNM completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your Claim is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice, and provide contact information for the Office of Superintendent of Insurance (toll-free number 855-427-5674 (1-855-4 ASK OSI)). http://www.OSI.state/nm.us

External review is available for *Adverse Benefit Determinations* and *Final Adverse Benefit Determinations* that involve rescission and determination that involve medical judgment including, but not limited to, those based on requirements for Medical Necessity, appropriateness, health care setting, investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program or a determination of compliance with the non-quantitative treatment limitation provisions of the Mental Health parity.

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, BCBSNM will assign the matter to an unbiased and independent review organization (IRO). The IRO assigned will be accredited by URAC (Utilization Review Accreditation Commission) or by similar nationally-recognized accrediting organization. Accordingly, BCBSNM must contract with at least three IROs for assignments under the plan and rotate Claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during BCBSNM's internal Claims and Appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    - — Your medical records;
    - — The attending Health Care Professional's recommendation;
    - — Reports from appropriate Health Care Professionals and other documents submitted by BCBSNM, you, or your treating Provider;
    - — The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
    - — Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
    - — Any applicable clinical review criteria developed and used by BCBSNM, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
    - — The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and you or your authorized representative.
- The notice of final external review decision will contain:
    - — A general description of the reason for the request for external review, including information sufficient to identify the Claim;
    - — The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - — References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    - — A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - — A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either BCBSNM and you or your authorized representative;

— A statement that judicial review may be available to you or your authorized representative; and

— Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- After a final external review decision, the IRO must maintain records of all Claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and by you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination,* BCBSNM immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim.

Expedited External Review

1. Request for expedited external review. BCBSNM must allow you or your authorized representative to make a request for an expedited external review with BCBSNM at the time you receive:

- An *Adverse Benefit Determination* if the *Adverse Benefit Determination* involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A *Final Internal Adverse Benefit Determination*, if the claimant has a medical condition where the time-frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the *Final Internal Adverse Benefit Determination* concerns an Admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but have not been discharged from a Facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the "Standard External Review" section above. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the "Standard External Review" section above. BCBSNM must provide or transmit all necessary documents and information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the Claim de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal Claims and Appeals process.

4. Notice of final external review decision. The IRO must provide notice of the final external review decision, in accordance with the requirements set forth in the "Standard External Review" section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSNM and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you have the right to request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal Claims and Appeals process. If you have been deemed to have exhausted the internal review process due to BCBSNM's failure to comply with the internal Claims and appeals process, you may also have the right to pursue any available remedies by contacting the APS Employee Benefits Department (6400 Uptown Blvd NE, Suite 115E, Albuquerque, NM 87110) or by mail at: Albuquerque Public Schools, Attn: Employee Benefits Department, PO Box 25704, Albuquerque, NM 87125-0704.

The internal review process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Claim Administrator demonstrates that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Claims Administrator.

External review may not be requested for an *Adverse Benefit Determination* involving a Claim for benefits for a Health Care Service that you have already received until the internal review process has been exhausted.

OTHER EXTERNAL ACTIONS

If you are still not satisfied after having completed BCBSNM's or, for eligibility and employee contribution issues, your employer's complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action at law or in equity may be taken or arbitration demand made earlier than 60 days after the Claims Administrator has received the Claim for benefits or Prior Authorization request, or later than three years after the date that the Claim for benefits should have been filed with the Claims Administrator.

Arbitration for Non-ERISA Plans — The "Arbitration for Non-ERISA Plans" provision applies to all Governmental Plans, Church Plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are non-resident aliens. If a dispute about coverage, benefits, or handling of Claims or appeals continues after you have followed and **exhausted** the appeals and grievance process set forth above, including having completed the external review process, the issue or Claim may be submitted to arbitration. The rules for arbitration shall be the "Commercial Arbitration Rules" developed by the American Arbitration Association. You may obtain a copy of these rules from a BCBSNM Customer Service Advocate. The rules are also available from the American Arbitration Association's website (www.adr.org).

Additional Resources — If you need additional assistance, you may call the U.S. Department of Labor's Employee Benefits Security Administration (EBSA):

Call toll-free at (866) 444-EBSA (3272) or visit the EBSA Web site at www.askebsa.dol.gov

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, NW
Washington, DC 20210

You may also contact the State of New Mexico Office of the Superintendent of Insurance:

Office of Superintendent of Insurance
P.O. Box 1689
Santa Fe, NM 87504
(855) 427-5674 (1-855-4 ASK OSI)
http://www.OSI.state/nm.us

RETALIATORY ACTION

BCBSNM and your employer shall not take any retaliatory action against you for making a complaint, filing an appeal, or requesting external review under this health plan.

NOTE: 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 Administrative Services Agreement.

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 **Albuquerque Public Schools** and Blue Cross and Blue Shield of New Mexico (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;
- the Members Identification Cards; and
- the *Plan Highlights*

In addition, **Albuquerque Public Schools** has important documents that are part of the legal agreement:

- the Benefit Program Application from the employer;
- the Administrative Services Agreement between BCBSNM and **Albuquerque Public Schools**; and.
- the APS Employee Benefits Enrollment Guide

The above documents constitute the entire legal agreement between BCBSNM and **Albuquerque Public Schools**. 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.

Albuquerque Public Schools reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This booklet is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative Claims payments only and does not assume any financial risk or obligation with respect to Claims, except as may be specified in the Administrative Service Agreement.

AMENDMENTS

BENEFIT BOOKLET NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or New Mexico law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section II. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of New Mexico (BCBSNM) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSNM for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the

Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider deductible and/or Out-of-Pocket Limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.







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