BlueCross BlueShield of New Mexico

Blue Preferred Exclusive Provider Option (EPO)

A Guide To Your Group Blue Preferred EPO Health Care Plan

NM481224 (01/20)

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 non-participating 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.

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
Toll-free telephone number: 1-800-432-0750

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

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

Preauthorizations: Medical/Surgical Services and Prescription Drugs—For Preauthorization 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 Preauthorization 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 Health and Chemical Dependency: For inquiries or Preauthorizations related to mental health 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 27630
Albuquerque, New Mexico 87125-7630

Website: For Provider network information, BCBSNM Drug List, 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.** See *Section 8: Claim Payments and Appeals* for details on submitting Claims.

Be sure to read this Benefit Booklet carefully and refer to the *Summary of Benefits*.

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

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

This Plan is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in health care. Like most people, you probably have many questions about your coverage. This Benefit Booklet contains a great deal of information about the services and supplies for which benefits will be provided under your Plan. Please read your entire Benefit Booklet very carefully. Wehope that most of the questions you have about your coverage will be answered.

Welcome to the Exclusive Provider Option (EPO) In-network Provider only health care benefit plan for eligible Subscribers of your Group 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 this health care benefit plan.

We refer to our company as ''BCBSNM'' in this Benefit Booklet, and we refer to the company or association that you work for as your ''Group.'' *Section 10: Definitions* will explain the meaning of many of the terms used in this Benefit Booklet. Whenever the term ''you'' or ''your'' is used, we also mean all Eligible Family Members who are covered under this Plan. Whenever the term ''we,'' ''us,'' or ''ours'' is used, it means 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.

BCBSNM or your Group may change the benefits described in this Benefit Booklet. If that happens, BCBSNM or your Group will notify you of those mutually agreed upon changes.

If you have any questions once you have read this Benefit Booklet, talk to your benefits administrator or call us at the number listed on the back of your ID Card, or as listed in *Customer Assistance* on the inside front cover. 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 Option (EPO) - Under the EPO Plan, you will receive benefits for nonemergency services only if you use a BCBSNM Blue Preferred EPO Provider. (You will be able to take advantage of the many Preferred Provider contracts that other Blue Cross Blue Shield Plans have throughout the United States.)

Welcome to Blue Cross and Blue Shield of New Mexico! We are very happy to have you as a member and pledge you our best service.

Sincerely,

Kurt Shipley President
Blue Cross and Blue Shield of New Mexico

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This Benefit Booklet describes the coverage available to Members of this Plan and the 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.
- Call BCBSNM (or the Behavioral Health Unit) for Preauthorization, if necessary. The phone numbers are on your Plan ID Card.
- 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.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

The Summary of Benefits and Coverage is referred to as the *Summary of Benefits* throughout this Benefit Booklet. The *Summary of Benefits* shows the specific Member cost-sharing amounts and coverage limitations of your Plan. If you do not have a *Summary of Benefits*, please contact a BCBSNM Customer Service Advocate (the phone number is at the bottom of each page of this Benefit Booklet). You will receive a new *Summary of Benefits* if changes are made to your health care 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 INFORMATION

The Provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all Providers in the Blue Preferred EPO network (in-state) and the BCBSNM Preferred Provider (PPO) network (out-of-state) and Participating Pharmacies. If you want a paper copy of a provider network directory, you may request one from Customer Service. It will be mailed to you free of charge. **Note:** Although Provider directories and information 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 provider network information directory, contact a Customer Service Advocate or visit the BCBSNM website.

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

BCBSNM has contracted with a separate pharmacy benefit manager to administer your Outpatient drug plan

benefits. In addition to your Benefit Booklet, you will be sent important information about your drug plan benefits. See your separately issued *Drug Plan Rider* for more information about the drug plan.

BLUECARD® BROCHURE

As a Member of an EPO health plan administered by BCBSNM, you take your health plan benefits with you for Emergency **services** – across the country and around the world for emergency healthcare. 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. When accessing non-Emergency services outside of New Mexico, you and your Eligible Family Members can receive the Preferred Provider level of benefits by using health care Providers that contract as Preferred Providers with their local BCBS Plan. Instructions for locating a Preferred Provider outside New Mexico can be found on the BCBSNM website at www.bcbsnm.com. When accessing non-Emergency services within New Mexico, you must choose a provider from the Blue Cross and Blue Shield Blue Preferred EPO℠ network of Providers to receive benefits under this plan.

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.

PREAUTHORIZATION 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 Standard Time. **Note:** Call Customer Service if you need Preauthorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive full benefits for Emergency Hospital Admissions, you (or your Provider) should notify BCBSNM as soon as reasonably possible following Admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard 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 Preauthorization before you are discharged.

Written Request Required

If a **written request** for Preauthorization 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 27630
Albuquerque, NM 87125-7630

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.

PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

All Inpatient and specified Outpatient mental health and Chemical Dependency services must be preauthorized by the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID Card). For services requiring Preauthorization, you or your Physician should call the BHU before you schedule treatment. The BHU will coordinate Covered Services with an In-network Provider near you. **If you do not call and receive Preauthorization before receiving non-Emergency services, benefits for services may be denied**. Call 7 days a week, 24 hours a day:

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

BCBSNM offers programs from time to time for the purposes of medical management programs, quality improvement programs, and health behavior wellness, maintenance or improvement. 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 these for participation in any program offered or administered by BCBSNM or any retailer, Provider, or manufacturer chosen by 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. These discounts and services may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at any given 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. 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. Blue Cross Blue Shield 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.

Contact Blue Cross Blue Shield for additional information regarding any value based programs offered by Blue Cross Blue Shield.

VIRTUAL VISITS

Covered Services provided via consultation with a licensed Provider through interactive video via online portal or mobile application. Virtual Visits provide access to Providers who can provide diagnosis and treatment of non-emergency medical and Mental Illness conditions in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit.

Virtual visit member cost share will be the same as an in-person primary care office visit and for behavioral health virtual visits, member cost share is the same as a behavioral health office visit in-person.

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 have guarantee that a particular vendor or service will be 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 Standard 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 the next business day.

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with Preauthorization requests
- check on a Claim's status
- help you change your PPP selection
- 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 on the inside cover of this booklet for important phone numbers, website, and mailing information. You can also email the Customer Service unit via the BCBSNM website noted below:

In addition to accepting email inquiries, the BCBSNM website contains valuable information about BCBSNM Provider networks, the BCBSNM Drug List, 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 behavioral health 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.

Toll-free: 1-888-421-7781

BLUE ACCESS FOR MEMBERS℠

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, and a program in which Members can earn merchandise for making healthy lifestyle choices and for participating in various activities. 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 Standard Time Saturday 6 A.M. - 2:30 P.M. Mountain Standard 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.

HEALTH CARE FRAUD INFORMATION

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

- Be wary of offers to waive Copayments, Deductibles, or Coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your Providers and the *Explanation of Benefits* (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call a BCBSNM Customer Service Advocate.
- Be very cautious about giving information about your health care insurance over the phone. If you suspect fraud, contact the BCBSNM Fraud Hotline at 1-888-841-7998.
- You can also contact the Office of Superintendent of Insurance if you suspect fraud.

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

Subject to the other terms and conditions of the Group Contract, the benefits described in this Benefit Booklet will be provided to persons who:

- Are active employees who have completed the Employee Probationary Period, if any, and who are regularly working the minimum number of hours specified in the Group Contract and their Eligible Family Members (No such probationary period may exceed 90 days unless permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations. If BCBSNM records show that your Group has a probationary period that exceeds the time period permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, then BCBSNM reserves the right to begin your coverage on a date that BCBSNM believes is within the required period. Regardless of whether BCBSNM exercises that right, your Group is responsible for your probationary period. If you have questions about your probationary period or the number of hours you must work per week or to learn of any other eligibility criteria specified by your Group, contact your Group's benefits administrator.);
- Have received a Blue Cross and Blue Shield Identification Card; and
- Reside or work in the geographic area ("Network Service Area") served by the Plan network for this Benefit Booklet. You may call customer service at the number shown on the back of your identification card to determine if you reside or work in the Network Service Area or log on to the web site at *www.bcbsnm.com*.

No eligibility rules or variations in premium will be imposed based on your 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, 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.

BCBSNM may request proof that a valid employer-employee relationship exists, if applicable, and/or that the applicant meets the eligibility requirements stated above and/or in the Group Contract and the Member's application.

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.

Working employees and their spouses age 65 and over may be entitled to the same benefits as those employees under age (See "Medicare-Eligible Members," later in this section.)

IF YOUR EMPLOYER OFFERS RETIREE BENEFITS

If your employer's Plan also covers retirees, retirees under the age of 65 who meet the employer's eligibility requirements for Plan participation are also eligible. **Note:** If you are a retiree covered under this Plan, please contact your employer's benefits administrator for eligibility criteria applicable to you.

ELIGIBLE FAMILY MEMBERS

Covered family member, covered spouse, covered Domestic Partner, covered Child - An eligible spouse, eligible Domestic Partner, 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 Domestic Partner (**Note**: Domestic Partner coverage is available at your employer's discretion. Contact your employer for information on whether Domestic Partner coverage is available for your Group.)
- the Subscriber's Eligible Child or the Eligible Child of the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) 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 - unless the Child is an Eligible Family Member under this Plan due to a disability as described below.)
- the Subscriber's unmarried Child or the unmarried Child of the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) 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 beyond age 26, 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.) For additional detail, see "Disabled Children Continued Coverage," *Section 9: General Provisions*.

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

- natural or legally adopted Child of the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners)
- Child placed in the Subscriber's home for purposes of adoption (including a Child for whom the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) is a party in a suit in which the adoption of the Child by the Subscriber or the Subscriber's spouse or Domestic Partner is being sought)
- stepchild of the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners)
- Child for whom the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) must provide coverage because of a court order or administrative order pursuant to state law
- eligible foster child of the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners)

A Child meeting the criteria above is an "Eligible Child" whether or not the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) 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 or the Subscriber's spouse or Domestic Partner 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, eligible foster child, or stepchild of the Subscriber or the Subscriber's spouse or Domestic Partner in order to retain eligibility as a family member under this health plan.

A **Domestic Partner** is a person of the same or opposite sex who meets all of the following criteria:

- shares your permanent residence and has resided with you for no less than one year;
- is not less than 18 years of age;

- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to BCBSNM on request.

In addition, you and your Domestic Partner will meet the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within 12 months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse, or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners if you reside in a state that provides for such registration. In any case, if your employer allows coverage for Domestic Partners and their children, BCBSNM will require a notarized *Affidavit of Domestic Partnership* and at least three corroborating documents:

- joint lease/mortgage or ownership of property
- jointly owned motor vehicle, bank or credit account (only one qualifies)
- Domestic Partner named as beneficiary of the employee's life insurance and/or retirement benefits, and/or as primary beneficiary under employee's will
- Domestic Partner assigned as power of attorney or legal designee by the employee
- both names on a utility bill and/or on an investment account

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 Special Enrollment Events.

Within 31 days of hire, you must submit all required forms to your benefits administrator. Once you have made an election during your initial enrollment period of 31 days from your date of hire, you are locked into that decision until the next annual open enrollment period.

BCBSNM may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, 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 the Plan will:

- provide such information to the custodial parent as may be necessary for the Child to obtain benefits through the 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 should then contact your benefits administrator 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.

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.

If Medicare is Primary

Special rules apply if a Member is receiving benefits from Medicare due to a disability or end-stage renal disease. In such cases, Medicare may be primary over this plan and benefits will be coordinated with Medicare as set forth in *Section 7*. Contact your benefits administrator for more information and for eligibility guidelines that apply to you.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your eligible spouse and/or dependents (see below) by submitting the application(s) to the Plan. The Application(s) for coverage may or may not be accepted. (BCBSNM cannot use genetic information or require genetic testing in order to limit or deny coverage.)

You may enroll in or change coverage for yourself and/or your eligible spouse and/or dependents during one of the enrollment periods described below.

Your Group and BCBSNM, as appropriate, may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Family Member under this Plan.

INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS / EFFECTIVE DATES OF COVERAGE

Your Group will designate initial and annual open enrollment periods during which you may apply for or change coverage for yourself and/or your Eligible Family Members.

You must submit all required forms to your benefits administrator within the initial enrollment period that your Group has designated from your date of hire. Once you have made an election during your initial enrollment period, you are locked into that decision until the annual open enrollment period designated by your Group that next follows your initial enrollment period.

An employee of the Group that becomes eligible for coverage outside of the initial or annual open enrollment period may apply for coverage in accordance with the Special Enrollment Periods/Effective Dates of Coverage below.

You and/or your Eligible Family Members' Effective Date of Coverage will be determined by the Plan in accordance with this section, "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" and the "Special Enrollment Periods/Effective Dates of Coverage" section below. Your Effective Date of Coverage will depend upon the date your application is received and other determining factors. Please contact your employer to determine your Effective Date of Coverage.

This section "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" is subject to change by the Plan, BCBSNM, and/or applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, as appropriate.

SPECIAL ENROLLMENT PERIODS / EFFECTIVE DATES OF COVERAGE

Special Enrollment Periods have been designated during which you may apply for or change coverage for yourself and/or your Eligible Family Members. You must apply for or request a change in coverage within 30 days from the date of a Special Enrollment Event (within 31 days of birth, if your Special Enrollment Event is gaining a dependent through birth) in order to qualify for the changes described in this Special Enrollment Periods/Effective Dates of Coverage section.

You must provide acceptable proof of a qualifying event. Special enrollment qualifying events are discussed in detail below. Blue Cross and Blue Shield of New Mexico will review this proof to verify your eligibility for a special enrollment. Please call the customer service number on the back of your identification card or visit our website at www.bcbsnm.com for examples of acceptable proof for the following qualifying events.

Special Enrollment Events:

- You gain a dependent or become a dependent through marriage or establishment of a domestic partnership, provided your employer covers Domestic Partners. New coverage for you and/or your eligible spouse or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective no later than the first day of the following month.
- You gain a dependent through birth, adoption or placement for adoption, assumption of eligible foster child care, or court-ordered dependent coverage. New coverage for you and/or your eligible spouse or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective on the date of the birth, adoption or placement for adoption, or placement for eligible foster child care. However, the effective date for court- ordered Eligible Child coverage will be determined by the Plan in accordance with the provisions of the court order.
- Your enrollment or non-enrollment in the Plan is unintentional, inadvertent, or erroneous as evaluated and determined by your Group or the Plan, as appropriate.
- You adequately demonstrate to the Plan that the health care plan in which you are enrolled substantially violated a material provision of its contract in relation to you.
- You gain access to new health care plans as a result of a permanent move.
- You demonstrate to the Plan, in accordance with the guidelines issued by the Plan, that you meet other exceptional circumstances as the Plan may provide.

Other Special Enrollment Events / Effective Dates of Coverage:

You must apply for or request a change in coverage within 30 days from the date of the below Other Special Enrollment Events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section. Coverage for you and your eligible spouse or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective no later than the 1st day of the month beginning after the date the Plan receives the request for other Special Enrollment.

- Loss of eligibility as a result of:

- — Legal separation, divorce, or dissolution of a domestic partnership, provided your employer covers Domestic Partners;
- — Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under the Plan);
- — Death of an Employee;
- — Termination of employment, reduction in the number of hours of employment.

- Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.
- Your employer ceases to contribute towards your or/your dependent's coverage (excluding COBRA continuation coverage).
- COBRA continuation coverage is exhausted.
- Loss of minimum essential coverage. Loss of minimum essential coverage does not include failure to pay premiums on a timely basis, including a failure to pay COBRA premiums, or situations allowing for a rescission;
- Loss of eligibility for coverage. This does not include loss of eligibility for COBRA continuation coverage

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Plan and BCBSNM, as appropriate.

This section "Special Enrollment Periods/Effective Dates of Coverage" is subject to change by the Plan, BCBSNM, and/or applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, as appropriate.

WHO IS NOT ELIGIBLE

The following individuals are not eligible for this coverage:

- Incarcerated individuals, other than incarcerated individuals pending disposition of charges.
- Individuals that do not live, **reside** or work in the Network Service Area
- Individuals that do not meet any Plan eligibility requirements or residency standards, as appropriate.

This section "Who is Not Eligible" is subject to change by the Plan and/or applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, as appropriate.

WHEN COVERAGE BEGINS

You and/or your Eligible Family Members' Effective Date of Coverage will be determined by the Plan in accordance with the sections above entitled "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" and "Special Enrollment Periods/Effective Dates of Coverage." Your Effective Date of Coverage will depend upon the date your application is received and other determining factors. Please contact your employer to determine your Effective Date of Coverage.

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 of Coverage 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 Family Coverage, or vice versa.

Your ability to change coverage types (e.g., from Family to Individual coverage, etc.) will depend on the rules and regulations set forth by your employer, including those described in the sections above entitled "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" and "Special Enrollment Periods/Effective Dates of Coverage." Please contact your employer for further information on 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) as provided under the "Special Enrollment Events/Effective Dates of Coverage" section above. **Within 31 days** of acquiring the newly Eligible Family Member, the Subscriber must:

- request that the employer notify BCBSNM of the change,
- complete and submit all necessary enrollment/change forms and legal documentation of proof of dependency, and
- pay any additional premium or other employee contribution for coverage.

Adding a Spouse or a Domestic Partner

If a Subscriber adds coverage for a spouse or Domestic Partner, provided Domestic Partners are covered under the Plan, **within 30 days** of marriage or establishment of a domestic partnership, the effective date of the new Eligible Family Member's coverage will as described under the "Special Enrollment Events/Effective Dates of Coverage" section above provided BCBSNM receives the completed and signed enrollment/change application form on a timely basis. If the Subscriber does not submit a completed and signed enrollment/change application form to his/ her benefits administrator or to BCBSNM (or to the COBRA administrator), along with necessary documentation **within 30 days** of marriage, the spouse may not be added to coverage except as a Late Applicant. Ask your employer which coverage types are available to you. See "Adding an Eligible Child," below.

Adding an Eligible Child

If you do not submit an application for an Eligible Child or add additional coverage, if required, within the time frames below, the Child will be considered a **Late Applicant**, except as may be provided under the "Special Enrollment Events/Effective Dates of Coverage" section above.

Newborn Children

A newborn, natural Child can be covered from birth, as long as enrolled within the stated timeframe. You must add coverage for the newborn **within 31** days of the birth in order for newborn care to be covered beyond day 31. In any case, if the application is not received **within 31** days and additional premium or other employee contributions for coverage, if any, are not paid, the newborn is considered a Late Applicant.

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.

AdoptedChildren/FosterChildren

A Child placed in the Subscriber's home for the purposes of adoption or foster care may be added to coverage as soon as the Child is placed in the home. However, application for coverage for adopted children can be made as late as **30 days** following legal adoption without being considered late. Although a Child over the age of 18 is not eligible for adoption, an adopted Child (or a foster child) is covered as any other Child, subject to the same Eligible Child age limitations and restrictions. **Note:** An adopted Child or foster child who is not enrolled within 30 days of adoption or placement in the home

for adoption or foster care will be considered a Late Applicant unless the Child was previously enrolled in a group health plan or other creditable coverage within 30 days of his/her adoption or placement for adoption or foster care and has had prior creditable coverage since that date with no significant lapse (i.e., 95 or more days).

Legal Guardianship

Application for coverage must be made for a Child for whom the Subscriber or the Subscriber's spouse becomes the legal guardian **within 30 days** of the court or administrative order granting guardianship.

Stepchild

Application for coverage must be made for a stepchild **within 30 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, if available and will **not** be considered a Late Applicant. 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 effective date of Family Coverage, or Employee/Children coverage, if available, whichever is later. BCBSNM must receive a copy of the court or administrative order.

LATE APPLICANT

Unless eligible as described in the "Special Enrollment Periods/Effective Dates of Coverage" section above, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** after birth of becoming eligible for coverage under this Plan (e.g., a newborn Child added to coverage more than 31 days after birth, a Child added more than 31 days after legal adoption, or a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the Group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as a provider under USERRA of 1994)

Application for coverage from Late Applicants will be accepted only during your Group's annual open enrollment period, except as described in the "Special Enrollment Periods/Effective Dates of Coverage" section above.

Note: Late applications are not accepted from retirees. If the retiree does not choose Plan coverage upon retirement, coverage may not be chosen at a later date. Late applications are also not accepted from persons applying for coverage under one of the continuation provisions listed under "How to Continue Coverage," later in this section. (There are federal and state regulations regarding the amount of time that a terminating plan Member has to apply for continued coverage when first eligible. See "How to Continue Coverage" for more information.

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" and "Special Enrollment Periods/Effective Dates of Coverage" section above 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 the Plan. (Members currently enrolled in continuation coverage may not re-enroll once coverage is terminated, unless eligibility under this Plan is re-established.)

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 Subscriber must notify the employer **within 30 days** following any changes that may affect his/her or a family member's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to the BCBSNM. You can obtain this form at BCBSNM's website at www.bcbsnm.com, from your Group's benefits administrator, or by calling the BCBSNM Customer Service department. (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.)

Employees and Their Eligible Family Members

Employees covered under the group Plan are responsible for completing and submitting signed enrollment/change forms to the Plan.

State Continuation Coverage

Employees covered under the group Plan are responsible for completing and submitting signed enrollment/change forms to the Plan.

COBRA Continuation Policy Members

If you are covered under a COBRA continuation policy, you must contact the COBRA administrator. The name, address, and phone number of the administrator will be provided to you should you elect COBRA coverage.

COVERAGE TERMINATION

If the employer or group administrator fails to submit premium payments to BCBSNM on a timely basis, coverage will terminate for all affected Members as of the end of the last-paid billing period. If your Group fails to submit premium payments to BCBSNM, it is your Group's contractual responsibility to advise members of the BCBSNM plan termination.

If your coverage is terminated for any reason,

- When you are no longer eligible for coverage under the Plan. The last day of coverage is the last day of the month that you become ineligible.
- The Plan terminates.
- When the Subscriber **dies**. (Surviving Eligible Family Members remain covered through the last-paid billing period.)
- 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** for the entire group or for the employee's or Subscriber's enrollment classification due to BCBSNM terminating such coverage.
- When the Group gives BCBSNM or BCBSNM gives the Group a minimum **30 days' advance written notice**.

- When an employee **retires.** (The retiree and his/her Eligible Family Members may be eligible for continuation coverage through federal law. See "How to Continue Coverage." Certain retirees who were covered under the Plan after retirement are allowed to remain covered under this Plan.)
- When the Subscriber moves to a primary residence or place of employment **outside the geographic area** serviced by BCBSNM. (See "How to Continue Coverage," later in this section.)

If BCBSNM ceases operations, BCBSNM will be obligated for services for the rest of the period for which premiums were already paid.

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:

- at the end of the **last-paid billing period**;
- at the end of the month when a Child **no longer qualifies as an Eligible Child** under the terms set by 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 following the dissolution of a domestic partnership, provided your employer covers Domestic Partners.

If a family member is being removed from coverage because of losing his/her eligibility under the terms set by the Plan (for reasons other than reaching the Eligible Child age limit), the enrollment/change form must be received by the Plan **within 30 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 your employer is responsible to adjust payroll deductions, if necessary. BCBSNM and the Providers of care may recover benefits erroneously paid on behalf of the removed member.

Note: If enrolled under federal continuation, send enrollment/change forms to the COBRA administrator.

Voluntary Termination of Coverage

To remove a family member from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, the Subscriber must submit a completed enrollment/change form to your employer. If voluntary termination is allowed under your Plan outside the annual or renewal period, coverage will end the first of the month following receipt of the enrollment/change form. Voluntarily terminated Members may re-enroll under the Plan only as Late Applicants (except as provided under "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" and "Special Enrollment Periods/Effective Dates of Coverage."). Also, these Members are **not** eligible for any extension of benefits or federal or state continuation or conversion coverage. Voluntarily terminated Members may apply for individual coverage offered by BCBSNM.

Note: If enrolled under federal continuation, send enrollment/change forms to the COBRA administrator.

Termination and Continuation of Coverage or Extension of Benefits

See "How to Continue Coverage" for more information.

Leave of Absence

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. Contact your benefits administrator for information.

NOTIFICATION

If the Group Contract is terminated or premiums are not submitted, coverage will terminate for all affected Members as of the end of the last-paid billing period. If your Group fails to sumit premium payments to BCBSNM, it is your Group's contractual responsibility to advise members of the BCBSNM plan termination.

The required premiums are determined and established by BCBSNM. The percentage of the total premium that you pay is established by your Group. BCBSNM may change premium amounts according to any of the following:

- changes in federal and state law; or
- changes to coverage classifications
- after giving the employer **60 days'** written notice.

PREMIUM REFUNDS

BCBSNM may not refund membership premiums paid in advance on behalf of a terminated Member if:

- the enrollment/change form is not received **within 30 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated Member during the period for which premiums have been paid.

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 are no Special Enrollment Events under these provisions. You must enroll timely to qualify for continued coverage.

Continuation Coverage

Your Group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA) or state law (six-month continuation). If so, employees and their covered family members excluding 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:

- the employer stops offering this coverage to its employees, *or*
- you do not elect continuation coverage within the applicable time periods as specified by law for federal continuation (COBRA), state continuation, Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) continuation, and/or extension of benefits due to total disability

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 your benefits administrator 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 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 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:

- the first of the month when you become entitled to Medicare
- 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.) **Exception:** If your Group declares bankruptcy and you are covered under this Plan as a retiree, you and your Eligible Family Members may be eligible for continued coverage.
- when you become covered under another group health care 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 of 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.")

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 your benefits administrator for an application for coverage and details.

Premiums for coverage may change on your group's renewal date or on any date that the Plan is amended. Written notice of any such change will be given to the Group or Subscriber at least 60 days before the effective date of the premium change.

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 your benefits administrator for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Extension of Benefits

If you are Totally Disabled on the date your group terminates coverage, your health care coverage may be continued (for only the disabling condition) for **up to 12 consecutive months** after the group terminates coverage with BCBSNM.

An extension of benefits is available if you:

- were Totally Disabled on the date of the group's termination; *and*
- incur an expense directly resulting from that particular disability that would have been a covered service before termination.

If coverage is continued under this provision, benefits for the disabling condition are paid subject to all applicable limitations, exclusions, and maximums that applied at the time the group's coverage terminated. To claim an extension of benefits, you must notify BCBSNM **within 30 days** of the group's coverage termination date and provide evidence of your total disability.

CONVERSION TO INDIVIDUAL COVERAGE

Involuntarily terminating Members may change to individual conversion coverage if this employer group health plan is still in effect and coverage is lost due to one of the following circumstances:

- termination of employment
- a Member no longer meets the eligibility requirements of the Plan
- the period of continuation coverage expires
- a covered family member loses coverage for one of the following reasons:
    - — divorce or legal separation from the Subscriber
    - — disqualification of the member under the definition of a Eligible Family Member
    - — death of the Subscriber
    - — an employee becomes primary under Medicare —leaving Eligible Family Members without coverage

The Subscriber and any Eligible Family Members who were covered at the time that group coverage was lost are eligible to apply for conversion coverage without a health statement.

BCBSNM must receive your application for conversion coverage **within 31 days** after you lose eligibility under the group/continuation Plan. **You must pay conversion coverage premiums from the date of such termination.**

Conversion coverage is **not** available in the following situations:

- when group coverage under this Plan was discontinued for the entire group or the employee's enrollment classification
- when you reside outside of or move out of New Mexico

Call a Customer Service Advocate for the enrollment options available to you.

The benefits and premiums for conversion coverage will be those available to terminated health care plan Members on your coverage termination date. You will receive a new Benefit Booklet if you change to conversion coverage. (Some benefits of this Plan are not available under conversion coverage.) Contact a Customer Service Advocate for details.

SECTION 3: HOW YOUR PLAN WORKS

BENEFIT CHOICES

Your Exclusive Provider Option (EPO) plan is a health care plan that provides benefits under agreement with an exclusive network of Preferred Providers. When you need nonemergency 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

Blue Preferred EPO Provider Services (Preferred Providers)
• You must use Blue Preferred EPO Providers except in an emergency and specified situations described under "Exceptions for Nonpreferred Providers" later in this Section. • You pay a Calendar Year Deductible and, depending on your Plan and the type of Covered Services received, as well as a percentage of Covered Charges (Coinsurance) after the Deductible(s) is met or, in some cases, you pay a fixed-dollar amount (Copayment) for a Covered Service. Services for which you pay only a fixed-dollar Copayment are not subject to the Deductible(s) (see "Cost-Sharing Features" for details). All other services are subject to Deductible(s) and Coinsurance. • You have an annual Out-of-Pocket limit (includes Deductibles, Coinsurance, and Copayments). • 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(s), Coinsurance, and/or 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 Preauthorizations for you. (Providers that contract with another BCBS Plan may call for Preauthorization on your behalf, but you will be responsible for making sure that Preauthorization is obtained when required. If you do not obtain Preauthorization, 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 Member's share of the Covered Charge (i.e., Deductible(s), Coinsurance, and/or Copayment, if any) as payment in full.

Nonpreferred Providers are Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "Preferred" or "PPO" Provider network. (These Providers may have "Participating Provider" agreements, but are **not** considered Preferred Providers. See "Participating and Preferred Providers" in *Section 8: Claim Payments and Appeals* for more information.) **Unless listed as an exception under "Exceptions for Nonpreferred Providers," 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 as an exception under "Exceptions for Nonpreferred Providers," benefits are not available for nonemergency services received from a Nonpreferred Provider.

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 health Providers (including those specializing in Chemical Dependency) and Participating Pharmacies. **Note:** Those Providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology, Oriental Medicine, 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 BCBSNM Blue Preferred EPO 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.

Finding a Pharmacy

To find a Participating Pharmacy, visit the Prime Therapeutics website at:

www.MyPrime.com

Click on *Find a Pharmacy*. You will then be asked to select from a list of BCBS Plans. **You must select "Blue Cross and Blue Shield of New Mexico"** and then select **"Other BCBSNM Plans"** in order to get the correct list of participating pharmacies for this health plan. After you have selected "Blue Cross and Blue Shield of New Mexico" as your health plan administrator, you will be able to locate participating pharmacies throughout the United States based on zip code or state name. You may also request a paper copy of the list of participating pharmacies by calling a Customer Service Advocate at BCBSNM.

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 *Summary of Benefits*. **Note:** Providers who have a "Participating Provider-only" contract are **not** Preferred Providers and you will not receive benefits when receiving services from Participating-only Providers. (See "Participating and Preferred Providers" in *Section 8: Claim Payments and Appeals* for more information.) You must use **Preferred Providers** in order to obtain benefits (unless listed under "Exceptions for Nonpreferred Providers," later in this section).

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

National Website

BCBSNM website: www.bcbsnm.com

Visit the Blue Cross and Blue Shield Association website at www.bcbs.com and click on the national "BlueCard Doctor and Hospital Finder," 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 Blue Cross Blue Shield Global Care 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 Preauthorization. You can find the Preauthorization phone number on your ID Card. **Note:** The phone number for Preauthorization 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

Exceptions for Nonpreferred Providers

There are four instances in which the services of a Nonpreferred Provider may be eligible for coverage:

Emergency Care

If you visit a Nonpreferred Provider for Emergency Care services, you will receive benefits for the initial treatment, which includes Emergency room services and, if you are hospitalized **within 48 hours** of an Emergency, the related inpatient hospitalization. (Office/Urgent Care Facility and Retail Health Clinic services are not considered "Emergency Care" for purposes of this provision.) You do not need Preauthorization before seeking *Emergency* services in an Emergency room. However, you should call BCBSNM within 48 hours of receiving the Emergency room care (or as soon as possible). **Care**

obtained from a Nonpreferred Provider without Preauthorization in any other setting (e.g., Physician's office or Urgent Care center) will not be covered.

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 or in the "Emergency and Urgent Care" provisions of *Section 5: Covered Services*.

Ancillary Providers

Once you have obtained Preauthorization for an inpatient Admission to a Preferred Provider 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 Provider, radiologist, anesthesiologist, pathologist, assistant surgeon, Emergency room Physician and/or other Hospital based Physician will be paid at the Preferred Provider level and you will not be responsible for any amounts over the Covered Charge. Please call customer service at the number on the back of your ID card if you have any questions about the benefits described in this section or how your claims are paid.

If a **Nonpreferred** surgeon provides your care or you are admitted to a Nonpreferred Hospital or other treatment Facility, you **will** be responsible for any services received from other Nonpreferred Providers during the Admission or procedure.

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 and Ambulance Providers). These Provider types are referred to as "Unsolicited Providers." The types of Providers that are unsolicited varies from state to state. If you receive Covered Services from an "Unsolicited Provider" outside New Mexico, you will receive benefits for those services. **However, the Unsolicited Provider may still bill you for amounts that are in excess of Covered Charges. You will be responsible for these amounts, in addition to your Deductible and Coinsurance or Copay.**

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 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.

If Medically Necessary Covered Services are reasonable not available through Network Professional Providers, BCBSNM and the Network Professional Provider will refer you to an out-of-network Professional Provider. BCBSNM will reimburse the out-of-network Provider at its usual & customary

rate or at an agreed upon rate. However, the payment for the out-of-network Provider will **not** exceed the payment that would have been made in the absence of any referral. Before BCBSNM denies any such referral to an out-of-network Provider, the referral request will be reviewed by a specialist similar to the type of specialist to whom the referral is requested.

Members who extend coverage under an extension of benefits due to disability after the Group Contract is terminated are not eligible to receive Preauthorization 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.

These are the only instances in which the services of a Nonpreferred Provider will be covered.

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 Member's 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 *Summary of Benefits* 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

See your separately issued Summary of Benefits for your Plan's specific cost-sharing features, such as Deductibles, Copayments and/or Coinsurance that you must pay, and your Out-of-Pocket Limit.

Most benefits are subject to a Deductible(s), Member Coinsurance, and an annual Out-of-Pocket Limit. For certain services, such as when you visit a Preferred Provider in his/her office, the Covered Charge is subject to either a fixed- dollar Copayment or Deductible and Coinsurance, depending upon your chosen Plan. Most other services of Preferred Providers are subject to the Deductible, Coinsurance, and Out-of-Pocket Limit provisions described below. Preferred Providers will not bill you for amounts in excess of the Covered Charge.

OFFICE VISIT COPAYMENT OR COINSURANCE

When you receive **office services** from a Preferred Provider (a "Primary Preferred Provider" (PPP) or PPO Specialist), you pay a Copayment or Coinsurance and Deductible for your covered **office visit** charge. All other services received during an office visit will be subject to the regular Deductible and/or Coinsurance requirements as listed on the *Summary of Benefits*.

OTHER FIXED DOLLAR COPAYMENTS

Besides office visits, other services (e.g., Emergency room and Outpatient Surgery) may also be subject to a fixed Copayment amount. These services may only require payment of the fixed Copayment amount or they may also require Coinsurance and a Deductible, depending on your chosen Plan. See the *Summary of Benefits* for more information.

Drug Plan Copayment

Depending upon the Plan you chose, your Drug Plan may have services subject to a fixed Copayment. See your separately issued Drug Plan Rider and the *Summary of Benefits* for more information.

DEDUCTIBLE

The Deductible is the amount of Covered Charges incurred by a Member that the Member must pay in a Calendar Year before this Plan begins to pay its percentage of that Member's Covered Charges incurred during that same Calendar Year.

If the Calendar Year 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 Covered Services received during the new Calendar Year are subject to the Deductible for the new Calendar Year.

If you changed health care benefit plan carriers during a Calendar Year, Covered Charges you incurred and which were applied to your annual or Calendar Year deductible during that part of the Calendar Year you were covered by your previous carrier will be applied to your annual Deductible for the remaining part of that Calendar Year under this Plan.

Individual Deductible

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

Family Deductible

For double or family coverage, with two enrolled Members, the Calendar Year Deductible requirement is fulfilled when both covered Members have each met their applicable individual Deductible, listed in the Summary of Benefits, during the Calendar Year. Refer to your Summary of Benefits for details.

What Is Subject to the Deductible

The following are **applied** to the Calendar Year Deductible. See your *Summary of Benefits* for more information.

- Charges covered under your Drug Plan Rider, depending upon the Plan you chose
- Coinsurance amounts

Timely Filing Reminder

Most benefits are payable only after BCBSNM's records show that the applicable Deductible has been met. Preferred Providers 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 Covered Services from Nonpreferred 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.**

COINSURANCE

For most Covered Services, you must pay a percentage of Covered Charges (Coinsurance) after you have met your Calendar Year Deductible and, depending on your Plan, as specified on your *Summary of Benefits*. After your share has been calculated, this Plan pays the rest of the Covered Charge, up to maximum benefit limits, if any.

Note: If you receive Covered Services from an "Unsolicited Provider," as defined in this section, you will be responsible for amounts over the Covered Charge.

Drug Plan Coinsurance

Depending upon the Plan you chose, your Drug Plan may have services subject to a Coinsurance. See your separately issued Drug Plan Rider and the *Summary of Benefits* for more information.

OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit is the maximum amount of Deductibles, 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 your Covered Charges for the rest of the Calendar Year, not to exceed any benefit limits.

Individual Limits

Once your Deductible, Coinsurance, and Copayment amounts for Preferred Provider services in a Calendar Year reach the individual amount indicated on the *Summary of Benefits,* this Plan pays 100 percent of your Covered Charges for the rest of the Calendar Year.

Family Limits

For double or family coverage, with two enrolled Members, the annual Out-of-Pocket requirement is fulfilled when both covered Members have each met their individual Out-of-Pocket amount listed on the Summary of Benefits during the Calendar Year. Refer to your Summary of Benefits for details.

What Is Included in the Out-of-Pocket Limits

The following amounts are applied to the out-of-pocket limits:

- fixed- dollar Copayments
- Coinsurance amounts
- Calendar Year Deductible
- *Drug Plan Rider* Copayments and/or Coinsurance amounts
- charges covered under your *Drug Plan Rider*

See the Summary of Benefits for your Deductible amounts, Copayments, Coinsurance percentages and Out-of-Pocket Limit amounts.

CHANGES TO THE COST-SHARING AMOUNTS

Copayments, Coinsurance percentage amounts, Deductibles, and Out-of-Pocket Limits are subject to change or increase as directed or permitted by law. 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 if changes are made to this Plan. If any benefit changes result in a premium increase, you will be given 60 days' notice of such changes.

If your Group 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 your Group changes to a higher Deductible, you will not receive benefit payments for services received after the change went into effect until the increased Deductible is met.

If your Group decreases the Deductible or Out-of-Pocket Limit amounts, you will not receive a refund for amounts applied to the higher Deductible or Out-of-Pocket Limit.

IF YOU HAVE MEDICARE

Note: This section applies to you only if you are primary under Medicare and Plan benefits are going to be coordinated with Medicare as a result.

If you have Medicare as your **primary coverage,** the Plan usually pays benefits only after Medicare has paid its portion of your covered Health Care Services. Medicare is called the "primary" coverage or carrier and pays its benefits first. The **GROUP** Medical Program is "secondary" coverage.

You may not elect to change your Plan to be primary coverage over Medicare and may not elect to bypass Medicare. If services are among those normally covered by Medicare, you or your doctor or Hospital (your

health care "Provider") must submit a Claim for those services first to Medicare. Medicare will calculate its benefits and will send you an *Explanation of Medicare Benefits* (EOMB) form. This form must be attached to any Claim you send to BCBSNM. **Note:** For services received in New Mexico, a "crossover" Claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. If your Claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. For details on how to submit Claims when your Claim is not automatically crossed-over from Medicare, see *Section 8: Claims Payments and Appeals.*

If you plan to receive a service that is not covered by Medicare (such as while outside the United States), it is your responsibility to call Customer Service and verify that the service will be covered under this Plan.

Active Employees and Employee Eligible Family Members

If you are an active employee or the Eligible Family Member of an active employee and are entitled to Medicare for any reason other than end-stage renal disease, this Plan pays benefits before Medicare and this section does not apply to you.

End-Stage Renal Disease

If you become eligible for Medicare *solely* due to having ESRD (i.e., you are *not* also age 65 or older and/or you are *not* also eligible for Medicare due to a non-ESRD disability), this Plan pays benefits **before** Medicare **only** during the "ESRD coordination time period." The length of this time period may change if changes are made in Medicare Secondary Payer laws. You will be advised of the length of the ESRD coordination time period once you begin Dialysis. This section does not apply to you if you are still within the initial ESRD coordination time period during which this Plan pays primary benefits.

If you complete the ESRD coordination time period or reach age 65 while eligible for Medicare as an ESRD patient, Medicare determines its benefits **before** this Plan pays its portion of Covered Charges. **This section of the booklet applies to such Members who are primary under Medicare; your Plan benefits will be coordinated with Medicare.** See **your employer** for enrollment rules.

Medicare-Eligible Retirees and Retiree Eligible Family Members

If you are a Medicare- eligible retiree or the Medicare-Eligible Family Member of a retiree receiving primary coverage from Medicare, Medicare determines its benefits before this Plan pays its portion of Covered Charges. **This section of the booklet applies to such Members who are primary under Medicare; your Plan benefits will be coordinated with Medicare. NOTE**: If you are a retiree and eligible for Medicare, see **your employer** for enrollment rules.

How Benefits are Paid

All expenses are subject to the same annual Plan Deductible, Copayment, Coinsurance, and Out-of-Pocket Limits. This Plan's benefits are determined and the balance due after Medicare or the usual Plan benefit will be paid, whichever is less. **Note:** You must be enrolled in both Parts A and B of Medicare in order to retain coverage under this Plan. If you privately contract with a Provider, BCBSNM will calculate amounts that would have been paid by Medicare and deduct those amounts from the billed charge for a Covered Service in order to arrive at a benefit payment, subject to Plan Deductible and Coinsurance or Plan Copayments.

Services that are not covered by Medicare may also be eligible for benefits under this Plan. See *Section 5: Covered Services* for a list of services that are covered by the Plan (services must be Medically Necessary and not listed as an exclusion in *Section 6: General Limitations and Exclusions).*

The following services are not subject to this Medicare coordination provision:

- non-Medicare-Covered Services that are not covered by the Plan and received at a Veteran's Administration, Department of Defense, or other government facility for a nonservice-connected

condition (for Outpatient Service, benefits are calculated using a maximum of 20 percent of the billed charge as the Covered Charge, which is then subject to regular Plan Deductible, Coinsurance, and/or Copayments. For Inpatient Services, the Covered Charge is equal to the Part A hospital deductible, subject to regular Plan Deductible, Coinsurance, and/or Copayment(s).

SECTION 4: PREAUTHORIZATIONS

Preauthorizations are a requirement that you or your Provider must obtain authorization from BCBSNM before you receive a certain type of Covered Services designated by Blue Cross and Blue Shield in order to be eligible for maximum benefits. However, for inpatient Hospital facility services, your Participating Provider is required to obtain Preauthorization. If Preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about prior authorization for services outside of our service area, see the section entitled, "THE BLUECARD® PROGRAM."

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.

Preauthorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. Preauthorization 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 the health insurance carrier, to be appropriate or necessary, according to:

a) any applicable generally accepted principles and practices of good medical care;
b) practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
c) any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

Please note:

Preauthorization 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 Preauthorization procedures must be followed. Failure to do so may result in a denial of benefits.

Most Preauthorization requests will be evaluated and you and/or the Provider notified of BCBSNM's decision within 5 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 Preauthorization 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 Preauthorization is not obtained before the service is received.

HOW THE PREAUTHORIZATION 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 if benefits for the proposed hospitalization or other services are preauthorized. If the Admission or other services are not preauthorized, 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 Preauthorization is not your responsibility — it is the Provider's. Preferred Providers must obtain Preauthorization 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 Preauthorizations," later in this section
- before recommending that you go to a Nonpreferred Provider for whose services you expect to receive benefits (Such requests may be denied.)

BCBSNM will advise you if a Preauthorization request is denied.

Note: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the Preauthorization 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 Preauthorization requirements.

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 Preauthorization, the Provider is not obligated to obtain the Preauthorization for you. In such cases, it is your responsibility to ensure that Preauthorization is obtained. If authorization is not obtained before services are received, 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.

Remember: Nonpreferred Providers are covered only for Emergency Care and in those specific circumstances described in the *"Exceptions for Nonpreferred Providers"* provisions of ***Section 3: How Your Plan Works***.

INPATIENT PREAUTHORIZATION

Preauthorization 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 Preauthorization"* below.

Type of inpatient Admission, re-admission,	**When to obtain inpatient Admission Preauthorization:**
Non-Emergency	Before the patient is admitted.
Emergency, non-Maternity	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 PREAUTHORIZATION

If you or your Provider do not receive Preauthorization 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 Preauthorizations," (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 may be denied. *

* 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 Preauthorization 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 PREAUTHORIZATIONS

In addition to Preauthorization review for all non-Emergency Inpatient Services, Preauthorization is required for certain other services listed below. Most Preauthorizations 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 Preauthorization. An out-of-network Provider, or an out-of-state Network Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is called. Preferred Providers that contract directly with BCBSNM are responsible for requesting all necessary Preauthorizations for you. (See *"Inpatient Preauthorization"* (or similar heading) for further information regarding inpatient Preauthorization requirements.)

If Preauthorization 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 Preauthorization Received:	Claim Disposition: Preferred	Claim Disposition: Nonpreferred
Service is Medically Necessary	Claim is paid based on Member's benefit plan	Claim is paid based on Member's benefit plan
Service is not Medically Necessary	Claim is denied; Member is held harmless	Claim is denied

Services that require Preauthorization:

- All inpatient Hospital Admissions
- The following Outpatient Services and procedures:
  - Air Ambulance (fixed wing and rotary) for non-emergent medical transportation
  - Home Health Care Services and home I.V. services
  - home infusion therapy (HIT), excluding antibiotics
  - outpatient infusion drugs
  - home hemodialysis
  - home Hospice services
  - Radiation Therapy
  - transitional care benefits
  - Dialysis for out-of-network services only
  - certain injections, including but not limited to intravenous immunoglobulin (IVIG)
  - molecular genetic testing
  - Outpatient Surgery performed at a Hospital or Ambulatory Surgical Facility for out-of-network services only
  - Transplant Evaluations and Transplants
  - Infertility procedures & Advanced Reproductive Technology
  - Outpatient Provider administered drug therapies, Cellular Immunotherapy, Gene Therapy and other Medical drug benefit therapies
  - Bariatric Surgery
  - Procedures that may be considered cosmetic under certain circumstances, e.g. Blepharoplasty
  - **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
  - Functional Neuromuscular Electrical Stimulation (FNMES)
  - Joint and Spine Surgery
  - Lumbar Spinal Fusion
  - Meniscal Allografts and Other Meniscal Implants
  - Orthopedic Applications of Stem-Cell Therapy
- **Pain Management:**
  - Occipital Nerve Stimulation
  - Surgical Deactivation of Headache Trigger Sites
  - Interventional Pain Management
  - Percutaneous and Implanted Nerve Stimulation and Neuromodulation
  - Spinal Cord Stimulation
- **Radiology:**
  - Advanced Imaging Services- CT, CTA, MRI, MRA, PET, PET/CT, and Nuclear Medicine (excludes Cardiac Advanced Imaging)
- **Sleep Medicine:**
  - Sleep Study (Facility based polysomnography/pap titration)
- **Surgical Procedures:**
  - Orthognathic Surgery
  - Mastopexy
  - Reduction Mammoplasty; Breast Reduction
- **Wound Care:**
  - Hyperbaric Oxygen (HBO2) Therapy

For specific details about the Preauthorization 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 Preauthorization during the Calendar Year. Updates to the list of services requiring Preauthorization may be confirmed by calling Customer Service.

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

The Preauthorization 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 Preauthorization. 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 "Advance Benefit Information/Predetermination" later in this section for further information.

PREAUTHORIZATION OF MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES

All inpatient mental health and Chemical Dependency services must be preauthorized by the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID Card. Preauthorization 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

Preauthorization 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 Preauthorization, 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 Preauthorization 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 Preauthorization of non-Emergency Inpatient Services, benefits for covered, Medically Necessary inpatient Facility care may be denied. If Inpatient Services received without Preauthorization 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 Preauthorization 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 Preauthorization for Outpatient Services before you start treatment.

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

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	**Type of Service:**	**Phone:**	**Send to:**

Request Preauthorization	Medical/Surgical	1-800-325-8334	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Health/ Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Customer Service Inquiry	Medical/Surgical	1-800-432-0750	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Health/ Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Submit Claim (post-service)	Medical/Surgical		BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Health/ Chemical Dependency		BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Request appeal or reconsideration of Claim or Preauthorization decision	Medical/Surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Health/ Chemical Dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Grievance Assistance- Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/Surgical; Mental Health/Chemical Dependency	1-800-427-5674	Office of Superintendent of Insurance P.O. Box 1689 Santa Fe, NM 87504-1689

IF YOUR PREAUTHORIZATION 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 Preauthorization 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 Preauthorization 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.

ADVANCE BENEFIT INFORMATION/PREDETERMINATION

If you want to know what benefits will be paid before receiving services or filing a Claim, BCBSNM may require a written request. BCBSNM may also require additional information and a written statement from the Provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation/Predetermination of benefits does not guarantee benefits if the actual circumstances of the case differ from those originally described. When submitted, Claims are reviewed according to the terms of this Benefit Booklet, your eligibility, or any other coverage that applies on the date of service.

UTILIZATION REVIEW/QUALITY MANAGEMENT

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

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this 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 below, it will be covered as long as that service is Medically Necessary and is not specifically excluded in this Benefit Booklet.**

Reminder: It is to your financial advantage to receive care from Primary Preferred Providers (PPPs) and other Preferred Providers.

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 your provider in consultation with BCBSNM's medical director to meet the following definition:

Medically Necessary/Medical Necessity is defined as health care services determined by a provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

a) any applicable generally accepted principles and practices of good medical care;
b) practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
c) any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health 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 the conditions of "Medically Necessary" 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 will determine Medical Necessity based on the criteria above.

If Medicare is Primary

When Medicare is primary (for example, you are a retiree or an Eligible Family Member of a retiree and eligible for Medicare due to age, you are under 65 and have exhausted the end- stage renal disease coordination time period under Medicare, or you are eligible for Medicare due to end-stage renal disease and turn age 65), if Medicare allows a service as Medically Necessary, the Plan will also consider it Medically Necessary. When Medicare determines that a service was not Medically Necessary, BCBSNM may (at your request) make its own determination regarding the service's Medical Necessity. However, for non-Medicare Covered Services, BCBSNM determines whether a service or supply is Medically Necessary and, therefore, whether the expense is covered under this Plan.

Preauthorizations 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.

Preauthorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. **Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits. (**For example, if you are not a covered Member at the time services are rendered.) 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.

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.

Outside the Service Area

Ambulance services are covered only in an Emergency. See "Emergency and Urgent Care" for details on obtaining Emergency Care.

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.

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. For more information, please consult BCBSNM's medical policies, which may be found on the BCBSNM website at:

http://www.medicalpolicy.hcsc.net/medicalpolicy/index?corpEntCd=NM1

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
- services ordered only because other transportation was not available, or for your convenience

AUTISM SPECTRUM DISORDERS

This Plan covers the Habilitative Treatment 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.

Treatment must be prescribed by the Member's treating Physician in accordance with a treatment plan. The treatment plan must be **Preauthorized** by 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 Preauthorized by BCBSNM must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services will be denied. **Note:** Habilitative services are defined as 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. There services 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.

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. 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 health 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 mailed to BCBSNM - **not** to the behavioral health services administrator.

Exclusions

This Plan does **not** cover:

- any Experimental, long-term, or maintenance treatments not required under state law unless listed above
- any 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 been preauthorized by BCBSNM
- respite services or care
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch or massage 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 Injuries to the jaw, mouth, face or Sound Natural Teeth are generally subject to the same limitations, exclusions and Member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, Medical Supplies, Surgical Services). This also includes services or supplies provided for the treatment of an accidental injury resulting from an act of domestic violence or a medical condition.

To be covered, *initial* treatment for the Accidental Injury should be sought as soon as possible after an accident to minimize any adverse effects that may occur due to lack of appropriate medical attention. Any services required after the initial treatment must be associated with the initial accident in order to be covered.

Facility Charges and General Anesthesia for Dental-Related Services

This Plan covers inpatient or outpatient Hospital expenses (including Ambulatory Surgical Facilities) and Hospital and Physician charges for the administration of general anesthesia for noncovered, Medically Necessary Dental- Related Services if the patient requires hospitalization for one of the following reasons:

- Because of the **patient's** physical, intellectual or medical condition(s), local anesthesia is not the best choice.
- Local anesthesia is ineffective because of acute infection, anatomic variation, or allergy to local anesthesia.
- The patient is a Member age 19 or younger who is extremely uncooperative, fearful or uncommunicative; his/her dental needs are too significant to be postponed; and lack of treatment would be detrimental to the child's dental health.
- Because oral-facial or dental trauma is so extensive, local anesthesia would be ineffective.
- There is a Medically Necessary dental procedure - not excluded by any general limitation or exclusion listed in this Benefit Booklet such as for work-related or Cosmetic services, etc. - that requires the patient to undergo general anesthesia or be hospitalized.

All Hospital Covered Services for dental procedures must be **preauthorized** by BCBSNM. **Note:** Unless listed as a Covered Service in this section, the Dentist's services for the procedure will not be covered.

Reminder: If Hospital Covered Services are recommended by a Nonpreferred (out-of-network) Provider, you are responsible for assuring that your Provider obtains Preauthorization for outpatient Covered Services or benefits may be denied.

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
- removal of exostoses or bony impacted teeth

TMJ/CMJ Services

This Plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ)/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/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 Noncovered 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
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, Noncovered 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, Appliances and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration.

Diabetes Self-Management Education

This Plan covers diabetes self-management training including if you have elevated blood glucose levels induced by pregnancy. Training must be prescribed by a health care Provider and given by a certified, registered, or licensed health care professional with recent education in diabetes management. Covered Services are limited to:

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

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 the legally blind
- insulin pumps and insulin pump supplies
- blood glucose monitors, including those for 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

Reminder: See your *Drug Plan Rider* for additional diabetic supply coverage of the following supplies: insulin; insulin needle and syringes; visual reading urine and ketone strips; lancets and lancet devices; prescriptive oral agents for controlling blood sugar levels; test strips for glucose monitors, and glucagon Emergency kits.

Note: The Plan will also cover items not specifically listed as covered when new and improved equipment, Appliances, and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration. This Plan will: 1) maintain an adequate formulary to provide these resources to individuals with diabetes; and 2) guarantee reimbursement or coverage for the equipment, Appliances, prescription drugs, insulin, or Medical Supplies described in this Benefit Booklet and/or your *Drug Plan Rid*er within the limits of this Plan.

EMERGENCY CARE AND URGENT CARE

Acute medical Emergency Care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition must meet the definition of an "Emergency" in order to be covered.

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.

Emergency Room

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 visit a Nonpreferred Provider for Emergency Care, the Preferred 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, covered follow-up care from a Non- preferred Provider is **not covered**. (Services received in an office or Urgent Care Facility are not considered Emergency Care for purposes of this provision.)

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 select a Preferred Provider to receive benefits for Covered Services.

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).

Care received in an Urgent Care Facility is subject to the Copayment, Deductible, or Coinsurance listed on your *Summary of Benefits*. If services are received in an Emergency room or other trauma center, the condition must meet the definition of an "Emergency" in order to be covered.

RETAIL HEALTH CLINIC CARE

This Plan covers Medically Necessary medical or surgical procedures, treatments, or services related to common illnesses and covered routine Preventive Services received at a Retail Health Clinic.

Care received in a Retail Health Clinic is covered as any other type of service.

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 for Members up to 21 years old.

Benefits for hearing aids and hearing aid-related services, such as hearing examinations and audiometric testing related to a hearing aid need, are subject to the usual plan Deductible, Coinsurance, and Copayment provisions for office services and diagnostic testing.

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.

Preauthorization Required

Before you receive home health care services and home I.V. therapy, your Physician or Home Health Care Agency must obtain **Preauthorization** from BCBSNM.

Covered Services

This Plan covers the following services, subject to the limitations and conditions above, when provided by an approved Home Health Care Agency during a covered visit in your home:

- Skilled Nursing Care provided on an intermittent basis by a Registered Nurse or Licensed Practical Nurse
- Physical, Occupational, or Respiratory Therapy provided by licensed or certified Physical, Occupational, or Respiratory Therapists
- Speech Therapy provided by a speech pathologist or an American Speech and Hearing Association certified Speech Therapist
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if
  Preauthorization is received from BCBSNM
- 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, see your separately issued *Drug Plan Rider.*)
- 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 *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, service or supply.

Exclusions

This Plan does **not** cover:

- care provided primarily for your or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient
- 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 approved by 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.

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
- drugs and medications for the Terminally Ill Patient
- 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 medicalcondition.)
- 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.)

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, 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

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, service or supply.

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

Preauthorization Required

If hospitalization is recommended by a Nonpreferred Provider in an emergency or you are outside New Mexico, **you are responsible** for obtaining Preauthorization. If you do not follow the inpatient Preauthorization procedures, benefits for covered Facility services may be **denied** as explained in *Section 4: Preauthorizations*.

Covered Services

For acute inpatient medical or surgical care received during a covered Hospital admission, this Plan covers semiprivate room and board or Special Care Unit (e.g., ICU, CCU) expenses and other Medically

Necessary services provided by the Facility. If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. BCBSNM must give **Preauthorization** for Medically Necessary private room charges to be covered at full benefits. If you did not receive Preauthorization, the Covered Charge for the additional cost of a Medically Necessary private room will be denied, which you will be responsible for paying, in addition to your Deductible(s) and/or Coinsurance. Private room charges that are not Medically Necessary will be denied. See *Section 4: Preauthorizations* for more information about Preauthorization requirements.

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 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. Preauthorization is required for all inpatient hospitalizations. See "Psychotherapy (Mental Health and Chemical Dependency)" for information about benefits for Chemical Dependency rehabilitation.

Exclusions

This Plan does **not** cover:

- Admissions related to Noncovered services or procedures
- Custodial Care Facility Admissions
- transplants or related services when transplant is received at a Facility that does not contract directly with a BCBSNM Participating Provider or through the BCBS transplant network

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.

LAB, X-RAY, OTHER DIAGNOSTIC 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.)
- infertility-relatedtesting
- PET (Positron Emission Tomography) scans, cardiac CT scans
- MRIs
- psychologicalor neuropsychological testing
- 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 Preauthorization 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 Preauthorization. The Medical Necessity requirements do not apply to mandated benefits, unless permitted by law.

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

See your Drug Plan Rider for additional information regarding contraceptive drugs and devices purchased from a pharmacy.

Family Planning

Covered family planning services include:

- 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 and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional method categories of contraception approved by the FDA
- pregnancy testing and counseling

For these following covered family planning services, no Coinsurance, Deductible, Copayment, or benefit maximums will apply when received from a Preferred Provider.

- over-the-counter female contraceptives and male contraceptives
- the contraceptives posted to the BCBSNM website [(www.bcbsnm.com/pdf/rx/contraceptive-list-nm.pdf)], or available by contacting your Customer Service Advocate at the toll-free number on your ID Card
- 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

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 the 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 noncovered, 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 noncovered 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.

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 semiprivate 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. The office visit during which a pregnancy is confirmed is subject to the member cost-sharing provisions that apply to any other office visit.) **Note:** Home births are not covered unless the Provider has a Preferred Provider contract with his/her local

BCBS Plan and is credentialed to provide the service.

- 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
- spontaneous, or therapeutic termination of pregnancy prior to full term

Special Beginnings

This is a maternity program for BCBSNM members that is available whenever you need it. It can help you better understand and manage your pregnancy. To take full advantage of the program, you should enroll within three months of becoming pregnant. When you enroll, you will receive a questionnaire to find out if there may be any problems with your pregnancy to watch out for, information on nutrition, newborn care, and other topics helpful to new parents. You will also receive personal and private phone calls from an experienced nurse – all the way from pregnancy to six weeks after your child is born. To learn more, or to enroll, call toll-free at:

1-888-421-7781

Newborn Care

You must add coverage within 31 days of birth in order for any newborn charges, routine or otherwise, to be covered beyond the first 48 hours of birth (or 96 hours in the case of a C-section).

Newborn Eligibility

If you do not elect to add coverage for your newborn within 31 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 as required by New Mexico state law.

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.

If you are in a nonpreferred Facility, 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 paid at the nonpreferred provider benefit level. 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, non-routine 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 a Physician or other Professional Provider for an illness or Accidental Injury.

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 non-routine office medical procedures — when not related to Hospice Care or payable as part of a surgical procedure.

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. Services must be received from a Preferred Provider in order to be covered.

Breastfeeding Support and Services

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

Genetic Inborn Errors of Metabolism

This Plan covers Medically Necessary expenses related to the treatment of Genetic Inborn Errors of Metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Covered Services include diagnosing, monitoring, and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, Medical Supplies, prescription drugs, corrective lenses for conditions related to the Genetic Inborn Error of Metabolism, nutritional management and **Preauthorized** Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

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.

Special Medical Foods

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 health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

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 **Preauthorization** is received from BCBSNM. Your BCBSNM-Contracted Provider has a list of those injectable drugs that require Preauthorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request Preauthorization, you may be directed to purchase the self-injectable medication through your drug plan.)

BCBSNM 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. **Note:** Certain drugs that have not been FDA-approved could be excluded. Call a BCBSNM Customer Service Advocate if you have any questions about this policy.

Mental Health Evaluation Services

This Plan covers medication checks and intake evaluations for Mental Disorders, alcohol, and Drug Abuse.

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
- 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*

PREVENTIVE SERVICES

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, not 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 (out-of-network services are subject to the usual out-of-network Deductible, Coinsurance, and Out-of-Pocket Limit):

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" website:

www.uspreventiveservicestaskforce.org/Page/ Name/recommendations);

b. immunizations for routine use that have in effect a recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

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, to the extent not described in item "a" above, evidence-informed preventive care and screenings 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.

The Preventive Services described in items "a" through "d" above may change as USPSTF, CDC, and HRSA guidelines are modified. For more information, you may visit the BCBSNM website at: www.bcbsnm.com/health/know_your_numbers or contact Customer Service at the toll-free number on your BCBSNM health plan Identification Card.

Covered Preventive Services **not** described in items "a" through "d" above may be subject to Deductibles, Coinsurance, Copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit. If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment, or setting in which it must be provided, BCBSNM may use reasonable medical management techniques to apply coverage. If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for any applicable Deductible, Coinsurance, Copayments, for the office visit only. If an office visit and the preventive health service are not billed separately and the primary purpose of the visit was not the preventive health service, you may be responsible for any applicable Deductible, Coinsurance, Copayments, for the office visit, including the preventive health service.

Examples of Covered Services include, but are not limited to:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- annual In Home Health Assessment
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- one baseline mammogram to women age thirty-five (35) through thirty-nine (39); one mammogram biannually to women age forty (40) through forty-nine (49); and one mammogram annually to women age fifty (50) or older
- papilloma virus screening and Cytologic Screening (a Pap test or liquid-based cervical cytopathology) to determine the presence of precancerous or cancerous conditions and other health problems (These tests are available for women age thirteen and older; and for women who are at risk for cancer, or at risk for other health conditions that can be identified through a Cytologic Screening.)
- human papillomavirus vaccine (HPV) for Members ages 9 - 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests

- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- periodic left- sided colon examination of 35 to 60 centimeters or colonoscopy
- Well-Child Care, including well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder (This routine service is not limited by the annual and lifetime maximum benefits for Applied Behavioral Analysis; see "Autism Spectrum Disorders" for additional Covered Services.)
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for Members when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your Physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use Cessation Counseling and obesity screening and counseling
- contraceptive drugs and devices

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
- hepatitis B immunizations when required due to possible exposure during the Member's work
- 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

Note: Routine Screening Mammography does **not** include "diagnostic mammography" which is a mammogram done after an 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 are found and removed. There would be no Member cost-share for the polyp removal and anesthesia during the Routine Screening Colonoscopy.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 colongraphy (sometimes referred to as "virtual colonoscopy").

Note: BCBSNM Preventive Care Guidelines may be found at the BCBSNM website below or contacting Customer Service:

www.bcbsnm.com/health/know_your_numbers

PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

Note: You do not receive a separate mental health/Chemical Dependency ID Card; use your BCBSNM ID Card to receive all medical/surgical and mental health/Chemical Dependency services covered under this Plan.

Medical Necessity

In order to be covered, treatment must be Medically Necessary and not Experimental, Investigational, or Unproven. Therapy must meet the following definition and conditions:

Medically Necessary/Medical Necessity is defined as Health Care Services that BCBSNM determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Hospital, Physician, or other Provider, and not more costly, as determined by BCBSNM or its agents, than an alternative clinical service, therapy, or procedure or sequence of services, therapies, and procedures that based on evidence-based clinical data are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For Psychotherapy (Mental Health 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.*

Preauthorization Requirements

Preauthorizations 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.

Preauthorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. **Preauthorization 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 Preauthorization

All inpatient mental health and Chemical Dependency services (e.g., partial hospitalization, residential treatment centers) must be Preauthorized by the Behavioral Health Unit at the phone number listed on the back of your ID card. Preauthorization 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

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 the *Preauthorizations* section, earlier. In such cases, you may be responsible for all charges, so please ensure that

you or your Provider have received Preauthorization 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 Preauthorization.**

Preauthorization 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.

Covered Services/Providers

Covered Services include solution- focused evaluative and therapeutic mental health 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*. Mental Disorders that respond to and require long- term treatment with medications and/or therapeutic treatment including schizophrenia, bi- polar disorder, and chronic depression are also covered.

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 health 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.

See your BCBSNM *Provider Directory* for a list of contracting Providers or check the BCBSNM website at www.bcbsnm.com.

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
- biofeedback, hypnotherapy, or behavior modification services
- religious or pastoral counseling
- Custodial Care
- hospitalization or admission to a Skilled Nursing Facility (SNF), nursing home, or other Facility

for the primary purposes 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 behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness. **Note:** This does not include 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 health conditions).
- 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 health professional practice
- the cost of any damages to a treatment Facility

REHABILITATION AND OTHER THERAPY

When billed by a Facility during a covered admission, therapy is covered in the same manner as the other ancillary services.

Acupuncture and Chiropractic Services

This Plan covers Acupuncture and chiropractic services when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of a medical condition. **Note:** If your Provider charges for other services in addition to Acupuncture or chiropractic, 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 chiropractic service will apply toward the "Short-Term Rehabilitation" benefit.

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.

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 reoccurrence, 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 y our 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 separately issued *Drug Plan Rider* will apply to

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

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

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

Dialysis

This Plan covers the following services:

- home hemodialysis when Preauthorized by BCBSNM
- Dialysis when Preauthorized by BCBSNM
- 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)

Preauthorization Required

To be covered, all **inpatient** Short-Term Rehabilitation treatments, including Skilled Nursing Facility and physical rehabilitation Facility admissions, must receive **Preauthorization** from BCBSNM.

Short-term rehabilitation services are provided in those instances when the Member's Physician determines that such services can be expected to result in the significant improvement of the Member's physical condition within a period of two (2) months. Benefits for such services may be extended beyond the two-month period with recommendation by the Member's Physician and Preauthorization from BCBSNM.

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 **Preauthorized** by 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, service or supply.

Benefit Limits

Benefits are limited as specified in the *Summary of Benefits.* **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 except as required under New Mexico State law
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law 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)
- private room expenses unless your medical condition requires isolation for protection from exposure to bacteria and diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- 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 nor 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 or rolfing

SUPPLIES, EQUIPMENT AND PROSTHETICS

Supplies or equipment that are dispensed by a Facility for use outside of the Facility are subject to the provisions of this "Supplies, Equipment and Prosthetics" section.

To be covered, items must be Medically Necessary and ordered by a health care Provider. If you have a question about Durable Medical Equipment, Medical Supplies, Prosthetics or Appliances not listed, please call the Customer Service number listed at the bottom of each page of this booklet.

Breast Pumps

This Plan covers the rental (but not to exceed the total cost) or, at its option, the purchase, of manual, electric and 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 is not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from a Preferred Provider. Electric breast pumps are limited to 1 per calendar year.

Contact Customer Service at the toll-free number on your ID Card for additional information on the benefits covered under this provision.

Durable Medical Equipment and Appliances

This Plan covers the following item**:**

- 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

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.

Medical Supplies

This Plan covers the following Medical Supplies, not to exceed a **30-day supply** purchased during any 30-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 (6 pairs 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 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 **four 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)
- orthotics (e.g., collars, braces, molds) prescribed by an eligible Provider to protect, restore, or improve impaired body function

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

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 non-medical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as chairlifts or beds; external Prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, 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
- 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
- stethoscopes or blood pressure monitors
- voice synthesizers or other communication devices
- 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
- 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 separately issued *Drug Plan Rider*).
- 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, Preauthorization from BCBSNM must be received for all inpatient surgical procedures except in the case of an Emergency.

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 (Bariatric) Surgery

Surgical treatment of Morbid Obesity is covered only if it is Medically Necessary and Preauthorization has been obtained from BCBSNM before treatment begins. There is a lifetime limit of one surgical procedure for the treatment 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
- 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 noncovered procedure (such as a noncovered 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. (See "Rehabilitation and Other Therapy" for information about Acupuncture benefits.)

Exclusions

This Plan does **not** cover local anesthesia, except for preventive 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

Preauthorization, requested in writing, must be obtained from BCBSNM **by the provider before** a pre-transplant evaluation is scheduled. A pre-transplant evaluation may not covered if Preauthorization 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.

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:

- 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 limit of this Plan (e.g., Deductibles, Coinsurance, Copayments and out-of-pocket limits; and annual home health care maximums).

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

This Plan covers Transplant-Related Services for a **heart, heart-lung, liver, lung or pancreas-kidney** Transplant. All other limitations, requirements, and exclusions of this "Transplant Services" provision apply to these Transplant- Related Services.

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 re- Transplant. 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 re-Transplant date.

Transplant Exclusions

This Plan does **not** cover:

- any Transplant or organ-combination Transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM Medical Necessity Guidelines)
- nonhuman organ Transplants
- are for complications of Noncovered 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
- drugs that are self-administered or for use while at home unless specifically covered under this Plan
- 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 kidney Transplant (unless services are not reasonably available within your community without travel)
    - 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 and your *Drug Plan Rider*.
Also see Section 5: Covered Services for specific benefit limitations and exclusions.

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, prescription filled, 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.

Biofeedback

This Plan does not cover services related to biofeedback.

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.

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, 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, unless Medically Necessary.**

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 surgery procedures following a covered mastectomy will be covered. However, **Preauthorization, 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 radiologytests.

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* and mandated by law. 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 contract exclusion.

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

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

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 services related to genetic counseling and testing that are not Medically Necessary.

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 (a preventive screening does *not* include a hearing test to determine the amount and kind of correction needed), or 3) covered as part of the hearing aid benefit for Members up to age 21 and described under "Hearing Aids/Related Services for Children Up To Age 21" in *Section 5: Covered Services.* **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 up to age 21**, see "Hearing Aids/Related Services for Children Up To Age 21" in *Section 5.*

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 non-Participating Provider if the Claim for such services is received by BCBSNM **more than 12 months** after the date of service. 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.

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 associated with educational needs only. 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, or any amendments, riders, addenda, or endorsements.

Local Anesthesia

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

Long-Term 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 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 required to be covered under New Mexico state law 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 (e.g., medical records, physician's letters, progress notes) from your Physician supporting his/her opinion.

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. **Exception:** The fact that this Plan covers certain services that are excluded under BCBSNM Medical Necessity Guidelines and certain services defined as Experimental or as maintenance therapy but which must be covered under New Mexico state law (such as Cancer Clinical Trials and applied behavioral analysis) does not mean that any other services will be or should be covered when contraindicated by BCBSNM Medical Necessity Guidelines. Only covered Acupuncture and those services mandated by state law will be excepted from this BCBSNM standard Medical Necessity Guidelines exclusion.

Medical Tourism

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

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.

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, or certain services that are reimbursed to the Department of Health according to the "Early Developmental Delay and Disability" provision in *Section 8: Claim Payments and Appeals*.

Noncovered Providers of Service

This Plan does not cover services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- Physician, other person, supplier, or Facility (including staff members) that are not specifically listed as covered in this Benefit Booklet, such as a:
  - health spa or health fitness center (whether or not services are provided by a licensed

or registered Provider)

- school infirmary
- halfway house
- 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

Nonemergency Services

This Plan does not cover nonemergency 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
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; "get-acquainted" visits without physical assessment or medical care; telephone consultations; filling out of Claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- 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
- 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 nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the Member's 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 nonemergency services provided by a Nonpreferred Provider unless **Preauthorization**

for such services is received from BCBSNM. You may be financially responsible for the services of a Nonpreferred Provider if you did not receive, in advance, a valid approval from BCBSNM. **Note:** When Preauthorization is requested, BCBSNM may require that you travel to another city to receive services from a Preferred Provider.

Except in Emergencies, BCBSNM will generally NOT authorize services of a Nonpreferred Provider if the services could be obtained from a Preferred Provider. Authorizations (Preauthorizations) for such services are given only under very special circumstances related to **Medical Necessity** and **lack of Provider availability in the BCBSNM Preferred Provider network.** BCBSNM will NOT approve an authorization request based on nonmedical issues such as whether or not you or your doctor prefer the out-of-network Provider or find the Provider more convenient. Regardless of Medical Necessity or non-medical issues, Nonpreferred Providers' services are NOT covered under this Plan, except during an Emergency, if you do not first obtain Preauthorization.

Nonprescription Drugs

This Plan does not cover nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed in the Drug List/Formulary or as covered in your separately issued *Drug Plan Rider.*

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.* This Plan covers other nutritional products only under specific conditions set forth under your *Drug Plan Rider.*

Post-Termination Services

This Plan does not cover any service received or item or drug purchased after your coverage is terminated, even if:

1) Preauthorization 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.)

Prescription Drugs

You should have received a separately issued *Drug Plan Rider* that explains your benefits for these items. All general limitations and exclusions listed in this *Section 6* also apply to items covered under the *Drug Plan Rider.*

Preauthorization Not Obtained When Required

This Plan may not cover certain services if you do not obtain Preauthorization from BCBSNM before those services are received.

Private Duty Nursing Services

This Plan does not cover private duty nursing services.

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, **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*
- Speech Therapy or diagnostic testing related to the following conditions: learning disorders, whether or not they accompany mental retardation; deafness; personality, developmental, voice, or rhythm disorders when these conditions are not the direct result of a diagnosed neurological, muscular, or structural abnormality involving the speech organs; or stuttering at any age (**Note:** Does not apply to Autism Spectrum Disorder.)
- services of a massage therapist or rolfing
- 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, except as required by law and described in *Section 5* under "Autism Spectrum Disorders" (See "Early Developmental Delay and Disability" in *Section 8: Claim Payments and Appeals* for coverage of certain services provided to eligible children by the Department of Health.)
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)

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* or under your vision care rider, if applicable. **This Plan does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses unless listed under your vision care rider, if applicable.

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 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 (unless a pre-existing conditions limitation applies).

Even when this Plan is secondary, all provisions must be followed. Failure to do so may impact your benefit payment from BCBSNM. The benefits BCBSNM provides for Covered Services may be reduced because of benefits received from the Other Valid Coverage.

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 information is not provided regarding the application of this provision.

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 have fulfilled its obligation to coordinate benefits appropriately.

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:

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

BCBSNM 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 BCBSNM has provided benefits as a result of that sickness or injury.

SECTION 8: CLAIMS PAYMENTS AND APPEALS

IMPORTANT NOTE ABOUT FILING CLAIMS

This section addresses the procedures for filing Claims and appeals. The instructions in no way imply that filing a Claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this Benefit Booklet. All Claims submitted will be processed by BCBSNM according to the patient's eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all Preauthorization requirements or benefits may be denied as explained in *Section 4: Preauthorizations.* 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. 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 and their services are **not** covered except during an Emergency or unless listed as an "exception" in *Section 3: How Your Plan Works.* 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.

PROVIDER NETWORK

Network Providers are not required to comply with any specified numbers, targeted averages, or maximum

durations of patient visits. You will not be held liable to a Network Provider for any sums owed to the Provider by BCBSNM.

NONPARTICIPATING PROVIDERS

A non-Participating Provider is one that has neither a Preferred or a Participating Provider agreement. If your non-Participating 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 Contracted 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 non-Participating Provider for any balance billing issues. If you need additional assitance 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) 407- 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:

- Member's identification number
- Member's and Subscriber's name and address
- Member's 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 non-Participating 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, U.S. Virgin Islands, and Puerto Rico

If a non-Participating 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 non- Participating 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 27630
Albuquerque, New Mexico 87125-7630

Mental Health/Chemical Dependency Claims

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

BCBSNM, BH Unit
PO Box 27630
Albuquerque, New Mexico 87125-7630

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 BCBSNM's 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. Refer to your Drug Rider for further claims submission information. You may also contact Customer Service for assistance.

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

For covered inpatient Hospital services received outside the United States (including Puerto Rico 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. Services received outside the United States (including Puerto Rico and the U.S. Virgin Islands) **will be covered only if they are for Emergency treatment.**

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 Blue Cross Blue Shield Global Care service center (the address is on the form). The *International Claim Form* is available from BCBSNM, the Blue Cross Blue Shield Global Care service center, or online at:

www.bcbs.com/already-a-member/coverage-home-and-away.html

The Blue Cross Blue Shield Global Care *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 your Blue Cross and Blue Shield Plan. 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 Care at the address below. Blue Cross Blue Shield Global Care 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 72017
Richmond, VA 23255- 2017

IF YOU HAVE MEDICARE

NOTE: This section applies to you only if you are primary under Medicare and Plan benefits are going to be coordinated with Medicare as a result. If you are not sure if Medicare is primary or secondary, please see "If You Have Medicare" in *Section 3: How Your Plan Works* for a brief explanation or call the Social Security office for more information.

Filing Claims if Medicare is Primary

If you have Medicare and Medicare is primary over this Plan (i.e., you are retired, a dependent of a retiree, or a Member that has exhausted the end-stage renal disease coordination time period under Medicare), when you receive health care, be sure to present both your Medicare ID card and your **Group** Plan ID Card issued by BCBSNM. Always present your Medicare ID card to your health care Providers so that they will bill Medicare first. After

Medicare has paid its portion **for services received in New Mexico,** a Claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. (If your Claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. Also, in order to ensure that Claims are filed properly, the Provider must have information from the ID cards issued to you by **both** Medicare and BCBSNM.)

If you must file a Claim for services that were covered by Medicare (for example, because services were received outside New Mexico and the Claim does not automatically "cross-over" once Medicare has paid its portion), you will have to file a copy of the *Explanation of Medicare Benefits* ("EOMB") that you receive from Medicare and all other required Claim information with the local BCBS Plan. ON the EOMB you receive from Medicare, **print your Plan ID number (found on your Plan ID Card issued by BCBSNM) - including the three alphabetic characters that precede the nine-digit number - and your correct mailing address and zip code.** Make a copy of the EOMB for your records.

Mail Claims, EOMBs, and other needed information to the local BCBS Plan in the state where you receive services. Your Provider should be familiar with this process, and in most cases, will file on your behalf. If you receive services in New Mexico and need to file a Claim to BCBSNM, send the Claim to:

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

Medicare-Covered Facility Services

All Medicare-participating Providers of Part A services, including Skilled Nursing Facilities and Hospice agencies, will submit Claims directly to Medicare. To file Claims, the Facility must have the information from the identification cards issued to you by **both** Medicare and BCBSNM.

After Medicare Part A has paid its portion of Covered Charges for services received in New Mexico, it is **not** necessary for you to file a Claim for most Facility services with BCBSNM. These Claims are automatically submitted by the Medicare Part A intermediary to BCBSNM. An *Explanation of Benefits* will be sent to you by BCBSNM after Plan benefits have been determined. If you must file your own Claim after Medicare pays its portion (for example, because services were received outside New Mexico), you must file a Claim for services received from the Hospital, along with Medicare's EOMB, **to the local BCBS Plan.** (See instructions in this section.)

Medicare-Covered Non-Facility Services

A Claim for Physician and other Professional Provider services must be filed **first** with Medicare Part B Medical Insurance. (All Medicare Providers must file Claims for you to Medicare.)

If you have given your Plan ID Card to your Provider, the Medicare Part B carrier will send an electronic copy of the Claim to BCBSNM **if the services are received in New Mexico.** If Medicare does not have your Plan ID number, you must file a copy of the EOMB and all other required information with BCBSNM after Medicare has sent an EOMB to you. Even though Providers may file Claims on your behalf, it is **your** responsibility to make sure that the Claim is filed to BCBSNM. If you must file your own Claim after Medicare pays its portion (for example, because services were received outside New Mexico), you must file the Claim for services received from the Provider, along with Medicare's EOMB, **to the local BCBS Plan.** (See instructions in this section.)

Services Not Covered by Medicare

You may have to file your Claim yourself. If your Provider does not file a Claim for you, you must submit a separate Claim form for each family member. Submit all Claims as the services are received. If a service is normally covered by Medicare, you must submit a copy of the EOMB (showing Medicare's denial reason) with the Claim form that you send to BCBSNM.

When an EOMB is Not Required

An EOMB indicating Medicare denied the service is required on all Claims except Claims for:

- services received outside the Medicare territorial limits
- services from Providers with whom you have privately contracted (BCBSNM will estimate what Medicare would have paid had you not privately contracted with the Provider and had submitted the Claim to Medicare for payment.)
- services received from licensed professional clinical mental health counselors (LPCC) and licensed marriage and family therapists (LMFT). (However, you will need **Preauthorization** from BCBSNM in order to receive benefits for covered mental health and Chemical Dependency services received from LPCC and LMFT Providers.)

NOTE: If the services you intend to receive would be covered by Medicare if you were to obtain the service from a Medicare-eligible Provider, you or your Provider must call BCBSNM for **Preauthorization** before receiving services from such a Provider. This will verify that the services being planned will be or will not be covered under the Plan and if the services require additional Preauthorization from BCBSNM. If a Medicare Provider is in your area and able to provide the services you need, you may be required to receive the service from a Medicare-eligible Provider in order to receive benefits under the **Group** Plan.

Services Outside Medicare Territorial Limits

When services are received outside the Medicare territorial limits, you must pay for the services or supplies. **Keep copies of your receipts.** File Claims as you would for any other service not covered by Medicare. (Medicare defines *Medicare territorial limits* as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.)

If you receive Covered Services while outside the United States, call the Blue Cross Blue Shield Global Care service center, collect, at 804-673-1177 for assistance with Claims filing. Or visit the Blue Cross and Blue Shield Association website to locate nearby participating Physicians and Hospitals.

To submit a Claim for services received outside the Medicare territorial limits, you do not need an EOMB.

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 Preauthorization 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. (See "Complaints/Appeals Summary," later in this section.) **You also have 180 days** following request of notification of an adverse benefit determination in which to appeal a decision to BCBSNM; however, you may exceed the 180- day limit when appealing to the Managed Health Care Bureau of the Office of Superintendent of Insurance**.**

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 noncovered expenses. For covered Emergency 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, and noncovered 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 com- promise, settlement, or judgement 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.

Early Developmental Delay and Disability

For covered children **under age four** who are also eligible for services under the New Mexico Department of Health's (DOH) "Family, Infant and Toddler" (FIT) program, as defined in 7.30.8, NMAC, your BCBSNM Plan will reimburse the DOH for certain Medically Necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH's FIT program. The maximum reimbursement under the BCBSNM Plan is **limited to $3,500** per year. How- ever, amounts paid to DOH for such services are not included in any annual or lifetime benefit maximums under the Plan. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the New Mexico DOH.

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 BCBSNM makes an erroneous benefit payment to the Subscriber or Member for any reason (e.g., Provider billing error, Claims processing error), BCBSNM may recover overpayments from you. If you do not refund the overpayment, BCBSNM reserves the right to withhold future benefit payments to apply to the amount that you owe the Plan, and to take legal action to correct payments made in error.

Pricing of Noncontracted Provider Claims

Except for certain categories of Claims described below, the BCBSNM Covered Charge for Covered Services received from Noncontracted Providers is the lesser of the Provider's billed charges or the BCBSNM "Noncontracting Allowable Amount." The BCBSNM Noncontracting 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). The Medicare Allowable is determined for a service covered under your BCBSNM health plan using information on each specific Claim and, based on place of treatment and date of service, is multiplied by an "Adjustment Factor" to calculate the BCBSNM Noncontracting Allowable Amount. The Adjustment Factor for non-Emergency services are:

- 100% of the base Medicare Allowable for inpatient Facility Claims
- 300% of the base Medicare Allowable for outpatient Facility Claims
- 200% of the base Medicare Allowable for freestanding Ambulatory Surgical Facility Claims
- 100% of the base Medicare Allowable for Physician, other Professional Provider Claims, and other ancillary Providers of covered Health Care Services and supplies

Certain categories of Claims for Covered Services from Noncontracted Providers are excluded from this Noncontracted Provider pricing method. These include:

- services for which a Medicare Allowable cannot be determined based on the information submitted on the Claim (in such cases, the Covered Charge is 50 percent of the billed charge)
- home health Claims (the Covered Charge is 50 percent of the billed charge)
- services administered and priced by any subcontractor of BCBSNM or by the Blue Cross and Blue Shield Association
- Claims paid by Medicare as primary coverage and submitted to your health plan for secondary payment
- New Mexico ground Ambulance Claims (for which the New Mexico Public Regulation Commission sets fares)
- covered Claims priced by a non-New Mexico BCBS Plan through BlueCard using local pricing methods
- the categories of Claims for Covered Services from Noncontracted Providers discussed in more detail below

Benefits for Emergency Care

If you receive treatment from a Nonparticipating Provider for Emergency Care, BCBSNM will review and process payment consistent with the In-Network benefit for the Covered Services provided. For services to be Covered Services, the services must be consistent with the definition of Emergency Care. As for air ambulance Emergency Care, you may be responsible for charges from the Nonparticipating Provider above any amount that BCBSNM pays that corresponds to the In-Network benefit level.

Pricing for the following categories of Claims for Covered Services from Noncontracted Providers will be priced at billed charges, at an amount negotiated by BCBSNM with the Provider, or other amount allowed by law, whichever is less:

- for PPO health plans, services from Noncontracted Providers that satisfy at least one of the two conditions below and, as a result, are eligible for the Preferred Provider benefit level of coverage

  -Covered Services from Noncontracted Providers within the United States that are classified as "Unsolicited Providers" as explained earlier in *Section 3: How Your Plan Works* and as determined by the Member's Host Plan while outside the Service Area of BCBSNM

  -**preauthorized** transition of care services received from Noncontracted Providers

Pricing for the following categories of Claims for Covered Services from Noncontracted Providers will be priced at either the sixtieth percentile of the allowed commercial reimbursement rate for the particular Covered Service based on claims paid in 2017, or at 150% of the 2017 Medicare Allowable for the Covered Service, whichever is greater. Unlike the pricing methods above, you will not be responsible for paying to the Noncontracted Provider the difference between the BCBSNM Covered Charge and the Noncontracted Provider's billed charge for a Covered Service.

- Covered Services required during an Emergency, excluding Covered Services received in an Ambulance; and
- Non-emergent Covered Services that have been preauthorized, if needed, and are rendered at a Contracted Facility where:
  - a Contracted Provider is unavailable;

- a Noncontracted Provider renders unforeseen Covered Services; or
- a Noncontracted Provider renders Covered Services for which you did not give specific consent to the Noncontracted Provider to render.

BCBSNM will use essentially the same Claims processing rules and/or edits for Noncontracted Provider Claims that are used for Contracted Provider Claims, which may change the Covered Charge for a particular service. If BCBSNM does not have any Claim edits or rules for a particular Covered Service, BCBSNM may use the rules or edits used by Medicare in processing the Claims. Changes made by CMS to the way services or Claims are priced for Medicare will be applied by BCBSNM within 90-145 days of the date that such change is implemented by CMS or its successor.

IMPORTANT: Regardless of which pricing method above is used, the BCBSNM Covered Charge will usually be less than the Provider's billed charge and **you will be responsible** for paying to the Provider the difference between the BCBSNM Covered Charge and the Noncontracted Provider's billed charge for a Covered Service. **This difference may be considerable.** The difference is **not** applied to any Deductible or Out-of-Pocket Limit. In the case of a noncovered service, you are responsible for paying the Provider's full billed charge directly to the Provider. **Reminder:** Contracted Providers will **not** charge you the difference between the BCBSNM Covered Charge and the billed charge for a Covered Service.

Provider Payment Example

The two examples below demonstrate the difference between your liability for services from a Nonpreferred Provider (when such services are **preauthorized** and **not** eligible for 100 percent coverage of billed charges) versus a Preferred Provider. Both examples are for a plan that pays 80 percent of Covered Charges with the remaining 20 percent of Covered Charges paid by the Member.

Example 1. Preferred Provider Claim Payment (Plan pays 80 percent; Deductible is met):

Provider's billed charge	$10,000
Covered Charges (maximum amount that can be considered for benefit payment)	$8,000
BCBSNM payment to Provider (80% of $8,000)	$6,400
Member Coinsurance (20% of $8,000) applied to the Out-of-Pocket Limit	$1,600
Amount over the Covered Charges - the Preferred Provider writes off the difference between billed amount and Covered Charge	$0
Total amount due from Member (Coinsurance only):	$1,600

Example 2. Non-Preferred Provider Claim Payment (Plan pays 80 percent; Deductible is met):

Provider's billed charge	$10,000
Covered Charges (maximum amount that can be considered for benefit	$8,000
BCBSNM payment to Provider (80% of $8,000)	$6,400
Member Coinsurance (20% of $8,000) applied to the Out-of-Pocket Limit	$1,600
Amount over the Covered Charges - the Member is responsible for all costs incurred over the Covered Charges and these amounts do not apply to your Out-of-Pocket Limits	$2,000
Total amount due from Member (Coinsurance only):	$3,600

Example 3. **(**In-network Hospital Plan pays 90%)(Out of Network Hospital Plan pays 70%)

Actual Hospital Charge	$10,500	$10,500
Amount Recognized by medical plan:	$6,500 (the discounted rate for health plan)	$8,800 (the Reasonable & Customary charges based on standard charge for that geographic area) Plan does not recognize the $1,700 difference between the actual charge and the R&C
Medical plan pays:	90% of the discounted rate: $6,500 x 90% = $5,950	70% of the discounted rate: $8,800 x 70% = $6,160
Member Pays:	10% of the discounted rate: $6,500 x 10% = $650	30 % of R&C charges ($8,800) plus 100% of the amount over R&C ($1,700): $2,640 + $1,700 = $4,340

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 Plans under their Licensed Controlled Affiliates ("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 healthcare services outside of the BCBSNM Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard program.

When you receive care outside of the BCBSNM Service Area, you will receive it from one of two kinds of health-care Providers. Most Providers ("Contracted Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some EPO Noncontracted 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 EPO** Primary Preferred Provider ("PPP") 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 **EPO** Contracted Providers. **EPO** Contracted Providers may be contracted with either BCBSNM or the Host Blue. **EPO** Noncontracted Providers are not contracted with either BCBSNM or the Host Blue.

When services are received by you outside of the State of New Mexico for either **EPO** Contracted or Noncontracted 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 **EPO** Contracted or Noncontracted 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 member's 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.

1. Services Received from EPO Contracted Providers outside New Mexico: BlueCard® Program

Under the BlueCard Program, when you receive Out-of-Area 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 **EPO** Contracted Providers.

For inpatient Facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Preauthorization. If Preauthorization 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 receive Out-of-Area Covered Services outside of the BCBSNM Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is based on the lower of:

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

If the services are provided by a **EPO** 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. 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 **EPO** 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 **EPO** 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 healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare 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 healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over-or underestimation of modifications 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, at its sole discretion, negotiate a payment with a noncontracting health care Provider on an exception basis.

Members may be responsible for the difference between the amount that the Noncontracted Provider bills and the payment that BCBSNM will make for Covered Services as set forth in this applicable section.

Federal law or state laws may require a surcharge, tax or other fee that applies to your liability calculation. If applicable, BCBSNM will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

2. Services Received from a EPO Noncontracted 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 **your EPO** Primary Care Physician ("PCP").

If services are provided by a **EPO** Noncontracted Provider, the Provider may, but is not required to submit claims on your behalf. If the **EPO** Noncontracted Provider does not submit claims on your behalf, you will be required to submit the claims directly to the Host Blue.

Member Liability Calculation

1. In General

Under Inter-Plan Arrangements, when services are received outside the state of New Mexico from a **EPO** Noncontracted Provider, the Covered Charge will be determined by the Host Blue servicing area or by

applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations and will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, BCBSNM may use other payment bases to determine the amount BCBSNM will pay for services rendered by Noncontracted healthcare providers, such as (i) billed charges for Covered Services, (ii) the payment we would make if the healthcare services had been obtained within our Service Area, (iii) a special negotiated payment as permitted under the InterPlan Arrangements; or (iv) for professional Providers, make a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or (v) for hospital or facility Providers. make a payment based on publicly available data reflecting the approximate costs that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the hospital or facility. In these situations, the Member may be responsible for the difference between the amount that the Noncontracted Provider bills and the payment that BCBSNM will make for Covered Services as set forth in this paragraph.

3. Emergency Care Services:

If you experience an Emergency while traveling outside the BCBSNM Service Area, go to the nearest emergency medical facility or trauma center.

4. 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 United States, you should call the Blue Cross Blue Shield Global Core 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 the service in order to determine the Covered Charge.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core 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 your claims to the Blue Cross Blue Shield Global Core 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.

Outpatient Services

Physicians, Urgent Care centers and other outpatient providers located outside the United States 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 United States, 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 Blue Cross Blue Shield Global Core service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNM, the Blue Cross Blue Shield Global Core service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

SUMMARY OF HEALTH INSURANCE GRIEVANCE PROCEDURES

Unless otherwise specified below: 1.) any reference to 1-5 days means only working days and excludes weekends and holidays; and 2.) any reference to 6 days or more means calendar days, including weekends and holidays.

This is a summary of the process you must follow when you request a review of a decision by your insurer. You will be provided with detailed information and complaint forms by your insurer at each step. In addition, you can review the complete New Mexico regulations that control the process under the Managed Health Care Bureau page found under the Departments tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy from your insurer at:

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

or from OSI by calling:

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

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

Adverse determination: You may request a review if your insurer has denied preauthorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (The insurer must notify you *before* terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by the insurer of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called **"adverse determinations."**

Administrative decision: You may also request a review if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

REVIEW OF AN ADVERSE DETERMINATION

How does preauthorization for a health care service work?

When your insurer receives a request to preauthorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

Coverage: First, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then your insurer will not agree to pay for you to have them even if you have a clear need for them.

Medical Necessity: Next, if the insurer finds that the requested service is covered by the policy, the insurer determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that your insurer pay for cosmetic plastic surgery to give you a more attractive nose, the insurer might certify the first request to repair your hand and deny the second, because it is not medically necessary.

Depending on terms of your policy, your insurer might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, the insurer may deny certification. Your insurer might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. However, you will be responsible for paying the provider yourself for the services.

How long does initial certification take?

Standard decision: The insurer must make an initial decision within 5 working days. However, the insurer may extend the review period for a maximum of 10 calendar days if it: **(1)** can demonstrate reasonable cause beyond its control for the delay; **(2)** can demonstrate that the delay will not result in increased medical risk to you; and **(3)** provides a written progress report and explanation for the delay to you and your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent Care situation: An **Urgent Care situation** is a situation in which a decision from the insurer is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum function; **(3)** the physician with knowledge of your medical condition **reasonably** requests an expedited decision; **(4)** the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or **(5)** the medical demands of your case require an expedited decision.

If you are facing an Urgent Care situation **or** your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer must either certify or deny the initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

If you are dissatisfied with the insurer's initial expedited decision in an Urgent Care situation, you may then request and expedited review of the insurer's decision by both the insurer and an external reviewer called an Independent Review Organization (IRO). When an expedited review is requested the insurer must review its prior decision and respond to your request within 72 hours. If you request that an IRO perform an expedited review simultaneously with the insurer's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours of receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide

When will I be notified that my initial request has been either certified or denied?

If the initial request is approved, the insurer must notify you and your provider within 2 working days after the decision, unless an urgent matter requires a quicker notice. If the insurer denies certification, the insurer must notify you and the provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review. **You may submit the request for review either orally or in writing, depending on the terms of your policy.** The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows:

Blue Cross Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, NM 87125- 7630
Medical/Surgical 1- 800- 205- 9926
Mental Health/Chemical Dependency 1- 888- 898- 0010
Fax (505) 816- 3837 or toll free at (800) 773- 1521

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing the written request for a review at:

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) 407- 5674
Fax: (505) 827- 6341, Attn: MHCB
Email: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination - first level review

If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify the insurer that you wish to request in internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that the insurer review its decision, the insurer will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review: If a review request involves an Urgent Care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review: Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your pre-service request for review. The medical director's review generally takes only a few days.

The medical director denied my request - now what?

- If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.
- If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel members. Your health provider may also address the panel or send a written statement.
- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may NOT request an IRO review if you skip the panel review.

How long do I have to make my decision?

If you wish to have your request reviewed by the insurer's panel, you must inform the insurer within **5 days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?

If you request that the insurer provide a panel review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone and address the panel or send a written statement.

The insurer's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you already received the services. You will be notified within 2 days after the panel decision. If you fail to provide records or

HINT: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for maximum of 30 days.

other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

If I choose to have my request reviewed by the insurer's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **4 months** to decide whether you want to have the request reviewed by an IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with the insurer or with you. The reviewer will consider all of the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the insurer must provider them.

The IRO's fees are billed directly to the insurer - there is no charge to you for this service.

How long does an IRO review take?

The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (however, if the IRO has been asked to provide an expedited review regarding an Urgent Care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within 20 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

REVIEW OF AN ADMINISTRATIVE DECISION

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within 180 days after the date you are notified of the decision. The insurer will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

The insurer will mail a decision to you within 15 days after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have 20 days to request that the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after the insurer receives your request. You will be notified at least 3 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 days.

The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855) 427-5674.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has 5 days to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and the insurer and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

GENERAL INFORMATION

Confidentiality

Any person who comes into contact with your personal health care records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulation.

Reporting requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

SECTION 9: GENERAL PROVISIONS

BCBSNM, Providers, and staff do not discriminate care based on whether you have signed any type of advance directive. If you have questions or concerns about advance directives, contact your PPP or personal Physician to discuss these issues.

APPLICATION STATEMENT

No statement (except a fraudulent statement) you make in any application for coverage that is **more than two years old** can void this coverage or be used against you in any legal action or proceeding relating to this coverage unless the application or a true copy of it is incorporated in or attached to the contract.

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 Preauthorization 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

BCBSNM may amend this Benefit Booklet when authorized by an officer of BCBSNM. BCBSNM will give your Group at least 60 days prior written notice of an amendment to this 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.

CONSUMER ADVISORY BOARD

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

DISABLED CHILDREN CONTINUED COVERAGE

BCBSNM, which provides for coverage of an Eligible Child of the Subscriber until the attainment of the limiting age of 26 for Eligible Children, shall not terminate the coverage of a Child while the Child is, and continues to be both incapable of self-sustaining employment, by reason of mental retardation or physical disability, and chiefly dependent upon the Subscriber for support and maintenance. However, proof of the incapacity and dependency of the Child must be furnished to BCBSNM by the Subscriber 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.

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.

ENTIRE CONTRACT

This Benefit Booklet (and any amendments, riders, endorsements, and the *Summary of Benefits*), and your Group enrollment/change application which is incorporated by reference into this Plan, shall constitute the entire contract. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

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.

FREEDOM OF CHOICE OF HOSPITAL AND PRACTITIONER

Within the area and limits of coverage offered to Subscribers and selected by the Subscriber in the application for insurance, the right of a person to exercise full freedom of choice in the selection of a hospital for hospital care or of a practitioner of the healing arts, or optometrist, psychologist, podiatrist, physician assistant, certified nurse- midwife, registered lay midwife, or registered nurse in expanded practice, for treatment of an illness or injury within that practitioner's scope of practice shall not be restricted under any new policy of health insurance, contract, or health care plan. Any person insured or claiming benefits under any such health insurance policy, contract, or health care plan providing within its coverage for payment of covered service benefits, or indemnity for hospital care or treatment of persons for the cure or correction of any physical or mental condition shall be deemed to have complied with the Plan requirements as to submission of proof of loss upon submitting written proof supported by the certificate of any hospital currently licensed by the department of health or any practitioner of the healing arts, or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice.

FREEDOM OF CHOICE OF INDEPENDENT SOCIAL WORKER

Within the area and limits of coverage offered to Subscribers and selected by the Subscriber in the application for insurance, the right of a person to exercise full freedom of choice in the selection of any independent social worker for treatment within that practitioner's scope of practice shall not be restricted under any new policy of health insurance, contract, or health care plan in this state or in the processing of any Claim thereunder. Any person insured or claiming benefits under any such health insurance policy, contract, or health care plan providing within its coverage for payment of covered service benefits, or indemnity for treatment of persons for the cure or correction of any mental condition shall be deemed to have complied with the Plan requirements as to submission of proof of loss upon submitting written proof supported by any independent social worker.

HOLD-HARMLESS

The contracts between BCBSNM and its Preferred Providers include a "hold harmless" clause which provides that an EPO Plan Member cannot be liable to the Provider for monies owed by BCBSNM for Health Care Services covered under the EPO health 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 responsibilities.
- 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 choose a PPP within the limits of the covered benefits and plan network, including the right to refuse care of specific practitioners.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- The right to receive from your Physician(s) or Provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of 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 prompt notification of termination or changes in benefits, services or Provider network.
- The right to file a complaint or appeal with BCBSNM or with the Office of Superintendent of Insurance and to receive an answer to those complaints within a reasonable time.
- The right to request information about any financial arrangements or provisions between BCBSNM and its Preferred Providers that may restrict referral or treatment options or limit the services offered to Members.
- The right to adequate access to qualified health professionals near your work or home within New Mexico.
- The right to affordable health care, with limits on Out-of-Pocket expenses, including the right to seek care from a Nonpreferred Provider, and an explanation of your financial responsibility when services are provided by a Nonpreferred Provider, or provided without required Preauthorization.

- 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 Preauthorization 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. and the right to request the assistance of the Office of Superintendent of Insurance.

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 Contracted 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.

PAYMENT OF CLAIMS

Claims submitted by a Member for Covered Services received by a deceased Member will be payable in accordance with the beneficiary designation and the provisions respecting such payments and effective at the time of payment. If no such designation or provision is then effective, Claims will be payable to the estate of the Subscriber. Any other Claims unpaid at the Member's death may, at our option, be paid to the beneficiary. All other Claims will be payable to the Subscriber.

PHYSICAL EXAMINATION AND AUTOPSY

If BCBSNM requires an independent medical examination before authorizing a service or processing a Claim, BCBSNM will cover the cost of the independent medical examination. In the unlikely event that BCBSNM requires an autopsy before paying a Claim, BCBSNM will pay the cost of the autopsy where it is not forbidden by law.

RELIGIOUS EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION

A certification(s) may have been provided to BCBSNM that your group health plan is established or maintained by an organization(s) that is a "religious employer(s)" as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Religious Employer Exemption"). Provided that the Religious Employer Exemption is satisfied for your group health plan, then coverage under your group health plan will not include coverage for some or all of such contraceptive services. Please call Customer Service at the number on the back of your ID card for more information. Questions regarding the Religious Employer Exemption should be directed to your Group. In addition, a certification(s) may have been provided to BCBSNM that your group health plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines

supported by the Health Resources and Services Administration ("Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under your group health plan will not include coverage for some or all of such contraceptive services. Please call Customer Service at the number on the back of your ID card for more information. If you have questions regarding the certification(s), you may contact your Group. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your ID card.

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.

TIME PAYMENT OF CLAIMS

Claims payable under this Plan for any loss other than loss for which this Plan provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued Claims for loss for which this Plan provides periodic payment will be paid not less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

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 your employer.

SECTION 10: DEFINITIONS

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 "Noncontracting Allowable Amount." Adjustment Factors will be evaluated and updated no less than every two years.

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.

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 — A facility where health care providers perform surgeries, including diagnostic and preventive sureries that do not require hospital admission.

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, "mal- adaptive" 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.

Benefit Booklet — This document or evidence of coverage issued to you along with your separately issued Summary of Benefits, explains the benefits, limitations, exclusions, terms, and conditions of your health coverage under your Plan.

Benefit Program Application (BPA) — The application for coverage completed by the Group and made a part of the Group Contract.

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.

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

healthcare 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 (BCBSNM) — 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 is a benefit 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 Member's 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 — The following family members of the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) are covered through the end of the month during which such family member turns age 26:

- natural or legally adopted child of the Subscriber or the Subscriber's spouse or Domestic Partner;
- child placed in the Subscriber's home for purposes of adoption (including a child for whom the Subscriber or the Subscriber's spouse or Domestic Partner is a party in a suit in which the adoption of the child by the Subscriber or the Subscriber's spouse or Domestic Partner is being sought);
- stepchild of the Subscriber or the Subscriber's spouse or Domestic Partner;
- eligible foster child of the Subscriber or the Subscriber's spouse or Domestic Partner;
- child for whom the Subscriber or the Subscriber's spouse or Domestic Partner must provide coverage because of a court order or administrative order pursuant to state law.

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.

Claim — Any request by a Subscriber for payment by a MHCP and/or any direct services provided to an individual.

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.

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 *Summary of Benefits*) of BCBSNM's Covered Charge after the Deductible (if any) has been met.

Contract Health Service — Any health service that is delivered based on a referral by, or at the expense of, an Indian health program and provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

Contracted — When a Provider 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 Member's share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services.

Copayment —A cost-sharing method that requires a covered person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the health insurance carrier paying the allowed balance; there may be different copayment amounts for different types of services under the same health benefits plan. Copayments are listed on the *Summary of Benefits*.

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

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 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.

> **Noncontracting Allowable Amount** — The maximum amount, not to exceed billed charges, that will be allowed for a Covered Service received from a Noncontracted Provider in most cases. The BCBSNM Noncontracting 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 Noncontracted Provider Claims payments for some Covered Services of Noncontracted 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:

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

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 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 — 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.).

Cytologic 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 — An 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 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.

Domestic Partner — A person of the same or opposite sex who meets all of the following criteria:

- shares your permanent residence and has resided with you for no less than one year;
- is not less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to BCBSNM on request.

In addition, you and your Domestic Partner will meet the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within 12 months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse, or spouse equivalent of the same or opposite sex.

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 List - A list of prescription drugs that are preferred for use by BCBSNM for retail and mail-order pharmacy benefits. The list is subject to periodic review and change by BCBSNM. BCBSNM-contracted providers should have received a copy of the list. If you need a list of commonly prescribed drugs on the BCBSNM Drug List, request it from a Customer Service Advocate or visit the BCBSNM website. Your drug plan may or may not use a Drug List. See your separately issued *Drug Plan Rider* for details

Drug Plan Rider — The document that explains the coverage available to you for prescription drugs, insulin, diabetic supplies, and certain nutritional products.

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

Effective Date of Coverage — 12:01 a.m. of the date on which a Member's coverage under this Plan begins.

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

- the Subscriber's legal **spouse**;
- the Subscriber's **Domestic Partner** (**Note**: Domestic Partner coverage is available at your employer's discretion. Contact your employer for information on whether Domestic Partner coverage is available for your Group.);
- the Subscriber's Eligible Child or the Eligible Child of the Subscriber's Domestic Partner (provided your employer covers Domestic Partners) are covered 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 rates adjusted accordingly - unless the Child is an Eligible Family Member under this Plan due to a disability as described below.);
- the Subscriber's **unmarried** Child or the **unmarried** Child of the Subscriber's Domestic Partner (provided your employer covers Domestic Partners) 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 beyond age 26 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.)

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

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

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 Experiment 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 or other institution.

Family Coverage — Coverage for you and your Eligible Family Members under this Plan as described in this Benefit Booklet.

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.

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

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

Group Contract — The Group Administration Document the Group's application to the Plan (Benefit Program Application), this Benefit Booklet, the Summary of Benefits and Coverage, and any other applications, riders, enclosures, addenda exhibits, and Amendments, or Endorsements, if any, between the Plan and the Group, referred to as the Group Contract.

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 outpatient 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.

Health Care Insurer — A person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, Health Maintenance Organization (HMO), nonprofit health care plan, prepaid dental plan, a multiple employer welfare arrangement or any other person providing a plan of health insurance or a Managed Health Care Plan subject to state insurance law and regulation.

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

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 Member's death, if sooner). The Hospice Benefit Period must begin while the Member is covered for these benefits, and coverage must be maintained throughout the Hospice Benefit Period.

Hospice Care — An alternative way of caring for Terminally Ill 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.).

Hospital Care — Hospital service provided by a hospital that is licensed as a hospital by the department of health and has accommodations for bed patients, a licensed professional registered nurse always on duty or call, a laboratory, and an operating room where surgical operations are performed. Hospital care does not include a convalescent, nursing, or rest home.

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).

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

In Home Health Assessment — Covered Services may include, but are not limited to, health history and blood pressure and blood sugar level screening. The assessment is designed to provide you with information regarding your heatlh that can be discussed with your health care Provider, and is not a substitute for diagnosis, management and treatment by your health care Provider.

Independent Social Worker — A person licensed as an Independent Social Worker by the board of

social work examiners.

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 health or Chemical Dependency care during any 24-hour period in a treatment Facility). Inpatient Services include, but are not limited to, semi-private room accommodations, general nursing care, meals, and special diets or parenteral nutrition when Medically Necessary, Physician and surgeon services, use of all Hospital facilities when use of such facilities is determined to be Medically Necessary by your treating Physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary, Radiation Therapy, inhalation therapy, and administration of whole blood and blood components when Medically Necessary.

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

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

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this health care plan (e.g., a newborn child added to coverage **more than 31 days** after birth, a child added **more than 31 days** after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the Group's initial enrollment
- 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.

Life-Threatening Disease or Condition — For the purposes of a Clinical Trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Managed Care — A system or technique(s) generally used by third party payors or their agents to affect access to and control payment for Health Care Services. Managed Care techniques most often include one or more of the following:

- prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services;
- contracts with selected health care providers;
- financial incentives or disincentives for Members to use specific Providers, services, prescription drugs, or service sites;
- controlled access to and coordination of services by a case manager; and
- payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

Managed Health Care Plan (MHCP) — 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). You may receive no benefits or reduced benefits for services received

outside of the network. 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.

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), or C-section.

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 Necessity Guidelines — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate Claims and provide benefits for Covered Services. Medical Necessity Guidelines are posted on the BCBSNM website for review or copies of specific Medical Necessity may be requested in writing from a Customer Service Advocate.

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 that BCBSNM determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Hospital, Physician, or other Provider, and not more costly, as determined by BCBSNM or its agents, than an alternative clinical service, therapy, or procedure or sequence of services, therapies, and procedures that based on evidence-based clinical data are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Medicare —Title 18 of the Social Security Amendments of 1965, *"Health Insurance for Aged and Disabled,"* as then constituted or later 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 Group Contract. 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.

Minimum Essential Coverage — Health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group, or government health insurance coverage.

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 obesity- related diseases or complications that are not controlled by best practice medical management:
  - — hypertension
  - — dyslipidemia
  - — diabetes mellitus
  - — coronary heart disease
  - — sleep apnea
  - — 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 etc.).

Network Service Area — The geographic area designated by BCBSNM, within which the Benefits of this Plan are available to Members. This Plan accepts Members if they reside, live or work in the geographic Network Service Area. In addition, routine non-Emergency services are generally limited to Providers within the Service Area. A Member may refer to the EPO Map and/or call the Customer Service Department at the number shown on the back of the Identification Card or visit the website at www.bcbsnm.com to determine if he or she is in the Network Service Area

Noncontracted — When a Provider 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.

Obstetrician-Gynecologist —A physician who is eligible to be or who is 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 semirigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

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

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 Services include those Hospital services that can reasonably be provided on an ambulatory basis and those preventive, Medically Necessary, diagnostic and treatment procedures prescribed by your attending Physician. Such services may be provided at a Hospital, a Physician's office, any other appropriate licensed Facility, or at any other appropriate Facility if the professional delivering the services is licensed to practice, is certified and is practicing under authority of the Health Care Insurer, a medical group, an independent practice association, or other authority authorized by applicable New Mexico law.

Outpatient Surgery — Any Surgical Service that is performed in an Ambulatory Surgical Facility or the outpatient department of a Hospital, but **not** including a procedure performed in an office or clinic. Outpatient Surgery includes any procedure that requires the use of an Ambulatory Surgical Facility or an outpatient Hospital operating or recovery room.

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 (PA)— A skilled person who is a graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of physical assistants, and who is licensed to practice medicine, usually under the supervision of a licensed physician.

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

Practitioner of the Healing Arts —A health care professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

Preauthorization —A pre-service determination made by a health insurance carrier regarding a covered person's eligibility for Health Care Services based on Medical Necessity, health benefits coverage and the appropriateness and site of services pursuant to the terms of the health benefits plan.

Predetermination — An advance confirmation, or "predetermination," of benefits for a requested Covered Service. Predetermination does not guarantee benefits if the actual circumstances of the case differ from those originally described.

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

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, Prostheses 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 licensed health care professional, hospital or other facility authorized to furnish health care services.

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 only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

Preferred Provider: A Provider who has contracted with BCBSNM as a Preferred Provider but does not practice in 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" or "HMO" 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 "Exceptions for Nonpreferred Providers."

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.

Participating Pharmacy: A retail supplier that has contracted with BCBSNM or its authorized representatives to dispense prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to Members covered under the drug plan portion of this Plan and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some Participating Pharmacies are contracted with BCBSNM to provide specialty drugs to Members; these pharmacies are called "Specialty Pharmacy Providers" and some drugs must be dispensed by these Specialty Pharmacy Providers in order to be covered.

A **Network Provider** agrees to provide Health Care Services to Members with an expectation of receiving payment (other than Copayments, Coinsurance or Deductible) 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**.**

Participating Provider — Any Provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross and Blue Shield (BCBS) Plan or the national BCBS Transplant network as a "Participating" Provider **only** and does not hold a Preferred Provider contract. Providers that have only a Participating Provider contract are **not** considered Preferred Providers and are paid at the Nonpreferred Provider Benefit level. However, they do obtain Preauthorization for the Member and bill BCBSNM directly just like a Preferred Provider. BCBSNM

pays them directly and they cannot balance bill the Member.

Nonparticipating Provider: A Provider that does not have either a Preferred or a Participating Provider contract and is paid at the Nonpreferred Provider Benefit level.

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.

QCMSO — A Qualified Child Medical Support Order.

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

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

Registered 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 health 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.

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.

Rescission — A cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Residential Treatment Center — 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, wilderness programs, 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.

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

Retail Health Clinic — A health care clinic located in a retail setting, supermarket, or pharmacy which provides treatment of common illnesses and routine preventive Health Care Services by Certified Nurse Practitioners. A "Participating" Retail Health Clinic has a written agreement with BCBSNM or another Blue Cross and Blue Shield Plan to provide services. A "Nonparticipating" Retail Health Clinic does not have a written agreement with BCBSNM or another Blue Cross and Blue Shield Plan to provide services.

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 — The cost for all items and services consistent with the coverage provided under this Plan that is typically covered for a Member who is not enrolled in a clinical trial. Routine Patient Care Cost does not include:

- the investigational item, device, or service itself;
- routine Hospital nursery services, including alpha-fetoprotein IV screening routine medical care in the Hospital after delivery pediatrician

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.

Note: BCBSNM Preventive Care Guidelines may be found at the BCBSNM website below or contacting Customer Service:

www.bcbsnm.com/Member / Health and Wellness

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 Care 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 31 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 formulated to be 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 health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty Pharmacy Provider — See definition of "Participating Pharmacy."

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 — An individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health benefits plan, or in the case of an individual contract, the person in whose name the contract is issued.

Summary of Benefits and Coverage (SBC) —The separately issued schedule that defines your Coinsurance requirements, Deductibles, Copayments, Out-of-Pocket Limits, and annual or lifetime benefits, and provides an overview of Covered Services. It is referred to as the *Summary of Benefits* throughout this Benefit Booklet.

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.

Temporomandibular Joint (TMJ)/Craniomandibular Joint (CMJ) Disorder — 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 and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Tobacco User — A person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your ID Card or visit our website at www.bcbsnm.com.

Totally Disabled — 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 re-Transplant and any subsequent hospitalizations and medical or Surgical Services related to a covered Transplant or re-Transplant, and received within one year of the Transplant or re-Transplant.

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 and Ambulance Providers). These Provider types are referred to as "Unsolicited Providers." The types of Providers that are unsolicited varies from state to state.

Urgent Care —A situation in which a prudent layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

- **(a)** the life or health of the covered person would otherwise be jeopardized;
- **(b)** the covered person's ability to regain maximum function would otherwise be jeopardized;
- **(c)** in the opinion of a physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without care or treatment;
- **(d)** the medical exigencies of the case require expedited care; or
- **(e)** the covered person's claim otherwise involves urgent care.

Utilization Management — A system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

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 developmental assessments and screenings, immunizations, and physical exams provided to children who have no symptoms of current illness as recommended by the American Academy of Pediatrics, and the U.S. Preventive Services Task Force (USPSTF).

SECTION 11: 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 your employer to determine if you or your Group are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage;
- when it may become available to you and your family if your Group is subject to the provisions of COBRA; and
- what you need to do to protect 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 Plan administrator or see *Section 2: Enrollment and Termination Information* of this Benefit Booklet.

The Plan administrator of the Plan is named by the employer or by the group health plan. Either the Plan administrator or a third party named by the Plan administrator is responsible for administering COBRA continuation coverage. Contact your Plan administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your Plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

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

Your eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens and if your Group is subject to the provisions of COBRA:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as an "eligible child".

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan administrator **within 30 days** when the qualifying event is:

- the end of employment;
- the reduction of hours of employment;
- the death of the employee;
- with respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- the enrollment of the employee in Medicare (Part A, Part B or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child losing eligibility for coverage as an eligible child), you must notify the Plan administrator. The Plan requires you to notify the Plan administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:

- the death of the employee;
- the enrollment of the employee in Medicare (Part A, Part B or both);
- your divorce or legal separation; or
- 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 Plan administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan administrator is notified of the Social Security Administration's determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and 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 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 Plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the Plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone 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 Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

BlueCross BlueShield of New Mexico

New Mexico Blue Preferred EPO℠ Service Area

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

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Blue Cross and Blue Shield of New Mexico

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Endorsement:

2020 Changes for all Small and Large Group PPO, EPO, and HMO Rx Riders

This endorsement is for all Small and Large Group, PPO, EPO, and HMO Rx Riders, and is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet.

EFFECTIVE DATE:

This endorsement is effective on January 1, 2020 or upon your Subscriber health plan's renewal date.

BY:

Kurt Shipley
President, Blue Cross and Blue Shield of New Mexico

Addition of new language:

Member Copayments and Coinsurance Section

If a covered Prescription Drug was paid for by using a drug manufacturer's coupon or copay card, this amount will not apply to Member's plan Deductible or Out-of-Pocket Limit.

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

6 Tier Copayment Drug Plan Rider for Group HMO Coverages

Blue Cross and Blue Shield of New Mexico

This document provides information regarding the drug plan portion of the health benefits plan you have chosen. It is to be used in addition to the medical plan portion described in your Blue Cross and Blue Shield of New Mexico (BCBSNM) Member's Benefit Booklet. Please add this information to the *Covered Services* section of your current Benefit Booklet. For those terms not defined in this rider, please refer to your Benefit Booklet's Definitions section.

BY:

Kurt Shipley
President
Blue Cross and Blue Shield of New Mexico

Definitions

Brand-Name Drug — A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from Generic to Brand- Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Brand-Name.

Coinsurance — The **percentage** amount of a Covered Charge paid by you for each covered prescription order filled or refilled or a covered supply purchased through a retail Pharmacy, Specialty Pharmacy provider, or designated mail-order service vendor after you have met your or your family's Deductible under this drug plan.

Copayment (or "Copay") — The maximum fixed-dollar amount you pay for each covered prescription order filled or refilled or a covered supply purchased through a retail Pharmacy. Specialty Pharmacy or designated mail-order service vendor under this drug plan.

Deductible — The annual deductible described in your Benefits Booklet for the medical portion of your health benefits plan that also applies to the drug portion of your health benefits plan described in this rider. This deductible is the maximum amount of Covered Charges you or your family must pay in a Calendar Year under your health benefits plan, including covered Pharmacy prescription charges for orders filled or refilled, or for covered supplies purchased through a retail Pharmacy, Specialty Pharmacy provider, or designated mail-order service vendor, before your health benefits plan begins to pay its share of Covered Charges, including the covered Pharmacy prescription charges you incur during the same Calendar Year under this rider. If a Deductible amount remains the same during the Calendar Year, you pay it only once each Calendar Year, and it applies to all Covered Charges that are subject to this Deductible and to Coinsurance that you receive during that Calendar Year including all covered Pharmacy prescription charges under this rider.

Drug List — A list of all drugs that may be covered under the Covered Medications and Other Items section of this rider. A current list is available on our website at https://www.bcbsnm.com/member/prescription-drug-plan- information/drug-lists. You may also contact a Customer Service Representative at the telephone number shown on the back of your Identification Card for more information.

Enteral Nutritional Product — 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).

Generic Drug — A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, BCBSNM uses the generic/brand status assigned by a nationally recognized provider of drug product database information. You should know that not all drugs identified as "generic" by the drug product database, manufacturer, Pharmacy, are considered "generic" for coverage purposes. Generic drugs are identified within The Drug List which is available on the BCBSNM Website at https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists. You may also contact a Customer Service Advocate for more information.

Genetic Inborn Errors 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.

Legend Drugs — Drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution: Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

Nonpreferred Brand-Name Drug — A covered Brand-Name Drug product or other item that is identified on the *Drug List* as non-preferred and is subject to the Nonpreferred Brand Name Drug tier payment level. The Drug List is available by accessing the website at https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists

Nonpreferred Generic Drug — A covered Generic Drug product or other item that is identified on the *Drug List* as nonpreferred and is subject to the Nonpreferred Generic Drug tier payment level. The Drug List is available by accessing the website at https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists

Nonpreferred Specialty Drugs — means a specialty drug, which may be Generic or Brand Name Drug, that is identified on the Drug List as a Non-Preferred Specialty Drug and is subject to the Non-Preferred Specialty Drug payment level. The Drug List is available by accessing the website at https://www.bcbsnm.com/member/prescription-drug-plan- information/drug-lists

Participating Pharmacy — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered Prescription Drugs, Medicines and Devices, insulin, diabetic supplies, and nutritional products to Plan Members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. Some Participating Pharmacies are contracted with BCBSNM to provide Specialty Drugs to Members; these Pharmacies are called **"Specialty Pharmacy providers"** and some drugs must be dispensed by these specially contracted providers in order to be covered.

Pharmacy — A state and federally licensed establishment that is physically separate and apart from any provider's office, and where Legend Drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

Pharmacy Benefit Manager — An entity with which BCBSNM has entered into one or more agreements for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under group health insurance policies and contracts to which BCBSNM is a party, including the health benefits plan to which this Drug Plan Rider is attached. (For more information, see section below entitled *"BCBSNM's Separate Financial Arrangements with Pharmacy Benefit Managers"*)

Preferred Brand-Name Drug — A covered Brand-Name Drug product or other item that is identified on the *Drug List* as preferred and is subject to the Preferred Brand Name Drug tier payment level. The Drug

List is available by accessing the website at: https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists.

Preferred Generic Drug — A covered Generic Drug product or other item that is identified on the *Drug List* as preferred and is subject to the Preferred Generic Drug tier payment level. The Drug List is available by accessing the website at https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists

Preferred Participating Pharmacy — A Participating Pharmacy which has a written agreement with BCBSNM to provide pharmaceutical services to Members or an entity chosen by BCBSNM to administer its prescription drug program that has been designated as a "Preferred Participating Pharmacy."

Preferred Specialty Drugs — means a specialty drug, which may be a Generic or Brand Name Drug, that is identified on the Drug List as a Preferred Specialty Drug and is subject to the Preferred Specialty Drug payment level. The Drug List is available by accessing the website at https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists

Prescription Drugs, Medicines, Devices — those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All Prescription Drugs, Medicines, and Devices must be approved by the FDA, and must not be experimental, investigational, or unproven. (See the "Experimental, Investigational, or Unproven Services" exclusion in your Benefit Booklet.

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 food- stuffs 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 errors of metabolism, and the Member is under the physician's ongoing care. Special medical foods are not for use by the general public and may not be available in stores or supermarkets. Special medical foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty Drugs — Specialty medications are used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies. Examples of conditions that may be treated with Specialty Drugs include hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with Specialty drugs. Specialty Drugs, when covered, are subject to the Deductible, and when the Deductible is met, the applicable payment level applies according to the Tier structure of the drug plan noted in your Summary of Benefits (see "Deductible and Coinsurance" section of this rider).

Specialty Drug List — A list of the names of Specialty Drugs which must be purchased through BCBSNM's Specialty Pharmacy provider. The *Specialty Drug List* is subject to periodic review and change by BCBSNM. If you need a list of Specialty Pharmacy drugs, request it from a Customer Service Advocate or visit the BCBSNM Website at www.bcbsnm.com.

How the Prescription Drug Program Works - When you are being treated for an illness or accident, your doctor may prescribe certain drugs or other Pharmacy items as part of your treatment. Your coverage includes benefits for drugs that are self- administered and other items listed below. This rider explains which drugs and other items are covered and the benefits available for them under this drug plan portion of your health care benefits plan. The benefits of this rider are subject to all of the terms and conditions of your health benefits plan. For example, benefits will be provided only if drugs and supplies are Medically Necessary. Please see the *General Limitations and Exclusions* section of your Benefit Booklet for a full list of exclusions that apply to all health care

services, including Prescription Drugs and other items under this rider.

Drugs listed on the Drug List are selected by BCBSNM based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of whom are employed by or affiliated with BCBSNM. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or prior authorization) occur only annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications will be made available to you. By accessing the BCBSNM website at https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists or calling the customer service toll-free number on your identification card, you will be able to determine the Drug List that applies to you and whether a particular drug is on the Drug List.

All drugs listed on the Drug List are covered unless specifically excluded. For example, if your health plan excludes weight management or obesity treatment, drugs for the treatment of obesity are also excluded. Prescription Drugs will not be excluded only because the drug has not been approved by the FDA for the treatment of your particular condition. Such a drug may be covered if it is recognized as safe and effective for the treatment of your condition in at least one standard medical reference compendium, including the "AMA Drug Evaluation," the "American Hospital Formulary Service Drug Information," and "Drug Information for the Healthcare Provider," OR is being provided during a covered cancer clinical trial as required under NM state law. The drug will not be covered, however, if it is excluded for another reason (such as being for weight loss, cosmetic, etc.).

You, or your prescribing health care provider, can ask for a Drug List exception if your drug is not on the Drug List (also known as a formulary). To request this exception, you, or your prescriber, can call the number on the back of your ID card to ask for a review. If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, you, or your prescriber, may be able to ask for an expedited review process. BCBSNM will let you, and your prescriber, know the coverage decision within 24 hours after they receive your request for an expedited review. If the coverage request is denied, BCBSNM will let you and your prescriber know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Please refer to your benefit booklet for more information regarding the appeals process, or you can call the number on the back of your ID card if you have any questions.

Covered Medications and Other Items — The following drugs, supplies, and other products are covered only when dispensed by a Preferred Participating Pharmacy or a Participating Pharmacy under the Retail Pharmacy or Specialty Pharmacy Drug Programs or when ordered through the designated Mail Order Service vendor:

- Prescription Drugs, prenatal vitamins, and medicines, unless listed as an exclusion when purchased from a Pharmacy.
- select vaccinations when received from certain Participating Pharmacies (For a list of Pharmacies that are contracted with BCSNM to provide this service, go to the BCBSNM Website at https://www.bcbsnm.com/provider_finder/important_info_rx.html.)
- insulin, glucagon, prescriptive oral agents for controlling blood sugar levels, and insulin needles, syringes, and other diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips) (There is a separate Copayment amount due for each item

purchased. These items are **not** covered as a supply or medical equipment expense under the medical portion of your health care benefits plan. See "Supplies, Equipment, and Prosthetics" in your Benefit Booklet for a list of diabetic equipment that *is* covered under the medical portion of your health care benefits plan.). NOTE: Durable medical equipment is **not** excluded for individuals with diabetes.

- nonprescription enteral nutritional products and special medical foods only when either: 1) delivered through a Medically Necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of Special Medical Foods (These products must be ordered by a physician and **preauthorization** received from BCBSNM in order to be covered.)
- treatment with FDA-approved Prescription Drugs (including prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health provider without prior authorization to assist you with quitting tobacco use or smoking. Also included is the following without cost-sharing:

Prior Authorization — Certain Prescription Drugs may require prior authorization from BCBSNM. A list of drugs requiring prior authorization is on the BCBSNM Website at: https://www.bcbsnm.com/member/prescription-drug-plan- information/drug-lists or contact customer service at the toll-free number on Your identification card. Your physician can request the necessary prior authorization.

Step Therapy – The step therapy program requires that the Member has a recent prescription history for a prerequisite medication before The Plan will cover a targeted - drug. A targeted - drug is a less-preferred or likely a more costly treatment option. A prerequisite drug is recognized as safe and works well in treating a specific medical condition, as well as being a cost-effective treatment option. If the Member and his/her doctor decide that a prerequisite drug is not right for the Member or is not as good in treating Member's condition, the doctor should submit a prior authorization request for coverage of the other drug.

When You submit a Prescription Order to a Participating Pharmacy for one of these targeted medications, the pharmacist will be alerted if the online review of Your prescription claims history indicates a prerequisite medication has not been previously tried. A list of step therapy medications is available to You and Your Health Care Practitioner on our website at https://www.bcbsnm.com/member/prescription-drug-plan- information/drug-lists or contact customer service at the toll-free number on Your identification card.

Benefits for Orally Administered Anticancer Medications — Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. No Deductible, Copayment amount or Coinsurance amount will apply to orally administered anticancer medications when received from a Participating Pharmacy. Coverage of prescribed orally administered anticancer medications when received from a non -Preferred Specialty Pharmacy provider or Non-Participating Pharmacy will be provided on a basis no less favorable than intravenously administered or injected cancer medications. If you have questions about your benefits for Orally Administered Anticancer Medications, you may contact Customer Service at the toll-free number on your ID Card.

Benefits for Contraceptive Drugs and Devices - Covered contraceptive drugs and devices are posted on the BCBSNM website (www.bcbsnm.com/pdf/rx/contraceptive-list-nm.pdf). This list is also available by contacting Customer Service at the toll-free number on your ID card.

Additionally, when received from a Participating Pharmacy:

- At least one Generic Drug or therapeutic equivalent in each category of contraception approved by the FDA will be covered with no Coinsurance, Deductible, Copayment, or benefit maximums.
- Up to a 6-month supply of contraceptives s available, if prescribed by your

If benefits for contraceptive coverage are denied, you or your representative may contact Customer Service at the toll-free number on the ID card to request an expedited review.

Retail Pharmacy Program — Your drug plan provides access to the Pharmacies in the retail pharmacy network. All items covered under the Retail Pharmacy Program must be purchased from a Participating Pharmacy unless there is an Emergency (as defined in your Benefit Booklet). For a list of Preferred Participating Pharmacies and Participating Pharmacies, call Customer Service at the phone number on the back of your ID Card and request a provider directory — or visit the BCBSNM Website at www.bcbsnm.com. The Pharmacies that are participating in the BCBSNM Retail Pharmacy Program may change from time to time. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

You must present your BCBSNM ID Card to the pharmacist at the time of purchase to receive this benefit. (You do not receive a separate prescription drug plan ID Card; use your BCBSNM health care plan ID Card to receive all medical/surgical and Prescription Drug services covered under your Plan, including this rider. Your Deductible and drug plan Coinsurance amounts are listed on your Summary of Benefits and Coverage (SBC).) You are responsible for paying the Deductible and any such Coinsurance amounts noted in this rider for certain covered items, any pricing differences when applicable, and limited or non-covered services. No Claim forms are required when you purchase your prescriptions at a Preferred Participating Pharmacy or Participating Pharmacy.

NOTE: Specialty Drugs must be purchased from the BCBSNM-designated Specialty Pharmacy, Alliance Rx Walgreen's Prime, provider in order to be covered unless coverage is specifically provided elsewhere in this rider and/or is required by applicable law or regulation.

You can use your ID Card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under the medical portion of your health care benefits plan, the ID Card may not be used to purchase drugs or other items for the terminated member(s). If you do not have your ID Card with you or if you purchase your drug or other item from an out-of-network retail Pharmacy you must pay for the purchase in full and then submit a Claim directly to the BCBSNM Pharmacy Benefit Manager, Prime Therapeutics, at the address below (do not send to BCBSNM). If not included in your enrollment materials, you can obtain the necessary Claim forms from a Customer Service Advocate or on the BCBSNM Website. In such cases, you will be responsible for 50% of the Covered Charge (i.e., the BCBSNM-contracted rate) applicable had you purchased these covered items at a Participating Pharmacy, plus the tiered Copayment amount corresponding to these covered items under your particular plan.

Send Retail Pharmacy claims to:
Prime Therapeutics
PO Box 25136
Lehigh Valley, PA 18002-5136

Specialty Pharmacy Program —This program provides delivery of medications directly to your provider's office or to your home if you are undergoing treatment for a complex medical condition. The Specialty Pharmacy Program delivery service offers:

- coordination of coverage among you, your health care provider, and BCBSNM educational materials about your condition and information about managing possible medication side effects
- syringes, sharps containers, alcohol swabs, and other supplies with every shipment of FDA-approved self-injectable medications
- access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days a year

This drug plan covers only those Specialty Drugs that are listed on the *Drug List.* The Drug List is on the BCBSNM Website at www.bcbsnm.com or can be obtained from a Customer Service Advocate by calling the phone number on the back of your ID Card. Your cost for Specialty Drugs is indicated under the "Member Copayments and Coinsurance" section below and you will be responsible for any Copayments, any pricing

differences when applicable, noncovered Specialty Drugs, and other limited or non- covered services that may apply to your coverage.

Mail Order Service — All items that are covered under the Mail Order Service are subject to the same limitations and exclusions as the Retail Pharmacy Program. Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service Advocate.) **Note:** Prescription Drugs and other items may **not** be mailed outside the United States.

IMPORTANT: Specialty Drugs are not covered through the Mail Order Service. You must use a Specialty Pharmacy provider designated by BCBSNM, Alliance Rx Walgreen's Prime, in order to receive benefits for Specialty Drugs.

Member Copayments and Coinsurance — For covered Prescription Drugs, insulin, diabetic supplies, and nutritional products, you pay the applicable tiered Copayment or applicable Coinsurance (see below), not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations described below). **See your *SBC* for your Copayment amounts. Any Coinsurance amounts due for certain covered items are noted in this rider.**

Each Calendar Year, the Copayments, Coinsurance percentage amounts, and any pricing differences between the cost of Brand-Name Drugs and their generic equivalents that you pay under this drug plan portion of your health care benefits plan are applied to you or your family's applicable annual out-of-pocket limit in combination with your medical and behavioral health for that Calendar Year under the medical portion of your health care benefits plan *(see your SBC)*. After you have met this out-of-pocket limit in combination with your medical and behavioral health under the medical portion of your health care benefits plan during a single Calendar Year, BCBSNM pays 100% of your covered prescription drugs, insulin, diabetic supplies, and nutritional products under this drug plan for the remainder of that Calendar Year. Noncovered charges may not be used to meet the out-of-pocket limit in combination with your medical and behavioral health under the medical portion of your health care benefits plan**.**

Your drug plan offers several benefit design Copayment options for when you purchase drugs or supplies from a Preferred Participating Pharmacy, a Participating Pharmacy a BCBSNM-designated Specialty Pharmacy provider, or BCBSNM- designated Mail Order Service vendor (see below for an example of a 6-Tier Copayment Drug Plan and how it works). When you need a prescription order filled, you should use a Preferred Participating Pharmacy or a Participating Pharmacy. Each prescription or refill is subject to the Copayment or Coinsurance shown on the SBC. Any Deductible shown in the SBC will also apply.

When you go to a Preferred Participating Pharmacy or a Participating Pharmacy, you must pay any Copayment, Deductible (if any), and any applicable pricing differences. You may be required to pay for limited or noncovered services. No claim forms are required. If you are unsure whether a Pharmacy is a Preferred Participating Pharmacy or a Participating Pharmacy, you may access the website at www.bcbsnm.com or contact Customer Service at the toll-free number on your ID Card.

In-network: In network pharmacy claims apply to in network deductible (if applicable). Copayment amounts paid at an in- network pharmacy would only apply to your in-network out-of-pocket limit.

Out-of-network: Pharmacy claims from an out of network pharmacy apply to out of network deductible (if applicable). Coinsurance and copayment amounts paid at an out of network pharmacy would only apply to your out of network out-of- pocket limit. Any additional charge for using an out of network pharmacy will not apply to your out of pocket amounts.

How Member Payment is Determined. Prescription drug products are separated into tiers. Generally, each drug is placed into one of six drug tiers:

- **Tier 1** includes mostly Preferred Generic Drugs and may contain some Brand Name Drugs.
- **Tier 2** includes mostly Non-Preferred Generic Drugs and may contain some Brand Name Drugs.
- **Tier 3** includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 4** includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 5** includes mostly Preferred Specialty Drugs and may contain some Generic Drugs.
- **Tier 6** includes mostly Non-Preferred Specialty Drugs and may contain some Generic Drugs.

You may not be required to pay the difference in cost between the Allowable Amount of the Brand Name Drug and the Allowable Amount of the Generic Drug if there is a medical reason (e.g., adverse event) you need to take the Brand Name Drug and certain criteria are met. Your Provider can submit a request to waive the difference in cost between the Allowable Amount of the Brand Name Drug and Allowable Amount of the Generic Drug. In order for this request to be reviewed, your provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your physician must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment Amount and/or cost share amounts will still apply. For additional information, contact the customer service number on the back of your identification Card or visit www.bcbsnm.com

To verify your payment amount for a drug, visit https://www.bcbsnm.com and log into Blue Access for Members or call the number on the back of your ID card. *Benefits will be provided as shown on the Schedule Page of this Policy.*

For additional information, please refer to the Outpatient Prescription Drug Section as shown on the Schedule Page of this Policy.

See your Summary of Benefits for the drug plan Copayment option that corresponds to the health benefits plan you have chosen. Except as may be specified elsewhere in this rider, drugs and supplies must be purchased from a Participating Pharmacy, or a BCBSNM-designated Specialty Pharmacy provider, or BCBSNM- designated Mail Order Service vendor in order to be covered under your drug plan.

For example, if the health benefits plan you chose features this option: $0/$10/$50/$100/$150/250		
Six-Tier Plan		
Preferred Participating Pharmacy Retail Pharmacy Up to a 30-day supply Extended Supply (if allowed by the Prescription order) up to a 90-day supply.	Tier 1[1]	$0 Copayment
	Tier 2[1]	$10 Copayment
	Tier 3[1,2]	$50 Copayment
	Tier 4[1,2]	$100 Copayment
Non-Preferred Participating Pharmacy Retail Pharmacy up to a 30-day supply	Tier 1[1]	$10 Copayment
	Tier 2[1]	$20 Copayment
	Tier 3[1,2]	$70 Copayment
	Tier 4[1,2]	$120 Copayment
Specialty Pharmacy Program Limited to a 30-day supply	Tier 5[1,2]	$150 Copayment
	Tier 6[1,2]	$250 Copayment

[1] Deductible may Apply [2] For all Brand-Name Drugs with an FDA-approved generic equivalent, if you or your provider order the brand-name, you will pay the Copayment, PLUS the difference in cost between the Brand-Name Drug and its generic equivalent.	
Select vaccinations received from certain Participating Pharmacies For a list of covered vaccinations see your drug list https://www.bcbsnm.com/member/prescription-drug-plan-information/drug- lists (For a list of Pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM Website at http://www.bcbsnm.com/provider_finder/important_info_rx.html	No Copayment
Mail Order Service (available for Tiers 1, 2, 3 and 4 only; Specialty Drugs are not covered through Mail Order Service)	**3 times Copayment** for Tier 1, 2, 3 or 4 drug
Nonprescription Enteral Nutritional Products and Special Medical Foods (requires preauthorization)	**Coinsurance of 50%** of Covered Charges

Under this drug plan, drugs are available at "tiered" Copayment levels. The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies, or insulin and insulin

syringes**,** or nutritional products obtained and whether they are obtained from a Preferred Participating Pharmacy, or a BCBSNM-designated Specialty Pharmacy provider**,** or BCBSNM- designated Mail Order Service vendor.

When the Copayment or Coinsurance amount for an item purchased under the drug plan is **greater** than the Covered Charge for the supply being purchased from a Participating Pharmacy, you pay the **least** of: 1) your Copayment or Coinsurance; or 2) the Pharmacy's retail price; or 3) the Covered Charge (i.e., the BCBSNM-contracted rate). For Claims submitted to the Pharmacy Benefit Manager for reimbursement, you are paid the **lesser** of: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a Participating Pharmacy, and any sales tax minus the applicable Member share, **or** 2) the Pharmacy's retail price minus the applicable Member share.

Supply Limitations — For each Copayment or Coinsurance listed for your drug plan, you can obtain the following supply of a single Prescription Drug or other item covered under this rider (unless otherwise specified):

Program Type	Supply Maximum	Copayment or Coinsurance Requirements
Nonprescription Nutritional Products	30-day supply during any 30-day period	**Coinsurance of 50% of Covered Charges (includes prescriptions for enteral nutritional products and special medical foods as described under "Covered Drugs and Other Items")**
Participating Retail Pharmacy and Specialty Pharmacy	During each one-month period, a 30-day supply	**Copayment for a 30-day supply.**
Preferred Participating Retail Pharmacy	During each three-month period, a 90-day supply when purchased from a Preferred Participating Pharmacy enrolled in BCBSNM's extended retail prescription drug supply program.	**Copayments for a 90-day supply.**

Mail Order Service (Tiers 1, 2, 3, and 4 only)	During each three-month period, a 90-day supply	**Copayments for a 90-day supply.**

Dispensing Limits – In addition to the supply limits stated above and regardless of the quantity of a covered drug prescribed by a physician, BCBSNM has the right to establish dispensing limits on covered drugs and over-the-counter contraceptives. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use and patient safety, and to reduce waste and stockpiling of drugs. Benefits for a covered drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid the BCBSNM-established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to BCBSNM on your behalf. The request will be approved or denied after the clinical information submitted by the prescribing doctor has been evaluated by BCBSNM.

Controlled Substances – If it is determined that a member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary or appropriate and restrictions may include but not be limited to a certain Provider and/or Pharmacy and/or quantities and/or days' supply for the prescribing and dispensing of the controlled substance medication. Additional copayment and/or coinsurance may apply.

Drug Plan Exclusions — In addition to services listed as not eligible for coverage in the *General Limitations and Exclusions* section of your medical plan portion's Benefit Booklet, this drug plan portion of your health benefits plan does **not** cover:

- Drugs which are not included on the Drug List unless specifically covered elsewhere in this drug rider and/or such coverage is required in accordance with applicable law or regulatory guidance.
- Prescription Drugs if there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan
- herbal or homeopathic preparations
- drugs which by law do not require a prescription order from an authorized health care practitioner (except insulin, insulin analogs, insulin pens, oral agents for controlling blood sugar level, and vaccinations administered through certain Participating Pharmacies)
- Legend Drugs or covered devices for which no valid prescription order is obtained
- non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Noncommercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration- approved indications provided by the ingredients' manufacturers.)
- prescriptions or other covered items purchased from a non-Participating Pharmacy provider or other provider unless eligible for benefits in an Emergency situation (as defined in your Benefit Booklet)
- refills before the normal period of use has expired, in excess of the number specified by the physician, or requested more than one year following the physician's original order date (Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply will have been exhausted according to the physician's instructions.) (Some prescriptions may be subject to a shorter refill window. Please call customer service for details.
- infertility medications

- Prescription Drugs that have over-the-counter equivalents, except all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescriptions and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
- drugs or other items for the treatment of sexual or erectile dysfunction
- devices or durable medical equipment of any type (even though such devices may require a prescription order) such as, but not limited to, therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices. ****NOTE**: Durable medical equipment is **not** excluded for individuals with diabetes.
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics)
- Tretinoin (sold under such brand names as Retin-A) for cosmetic purposes if you are age 40 or above
- unless the patient meets criteria for genetic inborn errors of metabolism and the product is **preauthorized** by BCBSNM); or nonprescription nutritional products that have not been preauthorized by BCBSNM
- Prescription Drugs in a drug class where there is an over-the-counter alternative available
- Over-the-Counter products except as required to be covered under Affordable Care Act or as required by New Mexico state law.
- shipping, handling, or delivery charges
- appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes
- ordinary foodstuffs that might be part of an exclusionary diet; any product that does not have and/or require a physician's prescription; food items purchased at a health food, vitamin or similar store; foods purchased on the Internet
- drugs determined to have inferior efficacy or significant safety issues
- covered drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under Workers' Compensation law
- drugs obtained by unauthorized, fraudulent, abusive, or improper use of an identification card
- drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the medical portion of health care benefits plan, or for which benefits have been exhausted
- any Prescription Drug for which the FDA has determined its use to be contraindicated for the treatment of the particular condition for which the drug has been prescribed
- any drugs which are not approved by the FDA for a particular diagnosis or indication, or when used for an indication other than the indication for which the FDA approval is given, except when: **a)** recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the healthcare provider;" **b)** when provided for cancer clinical trials, pursuant to Section 59A-22-43 NMSA; or **c)** as otherwise required under applicable law or regulation
- repackagers, institutional packs, clinic packs, or other custom packaging.

- Non-FDA approved Drugs
- bulk Powders
- diagnostic agents (except for diabetic testing supplies or test strips)
- Drugs that are not considered medically necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- administration or injection of any drugs, except select vaccinations as covered through your pharmacy benefits.
- Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia – National Formulary), including but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.

Drug Exclusions - Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, the plan may limit benefits to only one of the therapeutic equivalents available as specified on the Drug List. If you do not choose the therapeutic equivalents that are covered under the Outpatient Prescription Drug Program Benefit section, the drug purchased will not be covered under any benefit level.

Note: Prescription contraceptive devices are payable under the medical portion of your health benefits plan. Please see your Benefit Booklet's "Family Planning" provision under the "Covered Services" section.

Exceptions Process – You or your Provider can ask for a Drug List exception if your drug is not on the Drug List (also known as a formulary). To request this exception, you or your Provider can call the number on the back of your Identification Card to ask for a review. A determination will be made within 72 hours following receipt of the request and notice of the determination will be provided to the insured. If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug your Provider may be able to ask for an expedited review process by marking the review as an urgent request. The Plan will let you and your Provider know the coverage decision within 24 hours after we receive your request for an expedited review.

If an exception request is granted, The Plan will provide coverage of the drug for the duration of the prescription, including refills. If the coverage request is denied, the Plan will let you and your Provider know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination.

Call the number on the back of your Identification Card if you have any questions.

BCBSNM'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

All amounts payable to BCBSNM by Employer for Claim Payments provided by BCBSNM under the pharmacy benefit and applicable service charges pursuant to the terms of the Agreement and all required, deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Prescription Drug Program Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider, and BCBSNM, whichever is less, except as otherwise mutually agreed to by the parties.

Blue Cross and Blue Shield of New Mexico (BCBSNM) hereby informs you that it has contracts, either directly or indirectly, with participating prescription drug providers for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under group health insurance policies and contracts to which BCBSNM is a party, including this contract. Pursuant to BCBSNM's contracts with participating prescription drug providers, under certain circumstances described therein, BCBSNM may receive discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

BCBSNM may receive such discounts, although you are not entitled to receive any portion of any such discounts. The drug fees and/or discounts that BCBSNM has negotiated with Prime Therapeutics LLC (Prime) through the Pharmacy Benefit Management (PBM) Agreement will be passed-through to you for both retail and mail/specialty drugs, except as otherwise mutually agreed to. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to BCBSNM (and ultimately to Employer as described above).

To help you understand how BCBSNM's separate financial arrangements with participating prescription drug providers work, please consider the following example:

Assume you have a prescription dispensed and the undiscounted amount of the prescription drug is $100. How is the $100 bill paid?

You will have to pay the coinsurance amount set out in this Contract. For purposes of calculating your coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your coinsurance amount.

In our example, if your coinsurance obligation is 5%, you will have to pay 5% of $80, or $4. You should note that your 5% coinsurance amount is based upon the discounted amount of the prescription and not the full $100 bill.

For the mail and specialty pharmacy program delegated to Prime and subcontracted to Alliance Rx Walgreens Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail and/or specialty pharmacy program. BCBSNM pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail order processing.

"Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining BCBSNM's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in 34-day supply increments, so a 1-34 days' supply is considered 1 weighted claim, a 35-68 days' supply is considered 2 weighted claims, and the pattern continues up to 6 weighted claims for 171 or more days' supply. BCBSNM pays Prime a Program Management Fee ("PMF") on a per weighted claim basis. The amounts received by Prime from BCBSNM, pharmacies, manufacturers, or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to BCBSNM, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Contract. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of BCBSNM and other Blue Plan operating divisions.

BCBSNM'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

BCBSNM hereby informs you that it owns a significant portion of the equity of Prime and that BCBSNM has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers," or "PBMs"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under group health insurance policies and contracts to which BCBSNM is a party, including this Contract. PBMs have agreements with pharmaceutical manufacturers to receive rebates for using their products.

The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to the BCBSNM under the PBM's agreement with BCBSNM. This negotiation is conducted by the PBM for the benefit of BCBSNM and not for the benefit of the Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to BCBSNM (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). Each year, BCBSNM will calculate a projection of the amount of rebates it expects to receive from the PBM. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, such as Employer-specific demographics, retail, mail order and specialty pharmacy utilization, cost of prescription drugs, the Employer's benefit design, and rebate arrangements entered into by the PBM, none of which BCBSNM directly controls. BCBSNM's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all BCBSNM assets and revenue sources, are utilized by BCBSNM in various ways to enable BCBSNM to provide cost-effective products and services. Additional information about rebates, the PBM and the Rebate Credit will be available upon request. The BCBSNM may provide the Employer with a Rebate Credit, the amount of which is set forth in the ASO BPA. The Rebate Credit provided to Employer will be provided from BCBSNM's own assets and may or may not equal the entire amount of rebates provided to BCBSNM by the PBM. The Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its group health plan have no right to, or legal interest in, any portion of the rebates provided by the PBM to BCBSNM and consents to BCBSNM's retention of all such rebates. Rebate Credits shall not continue after termination of the prescription drug program.

The maximum that a Pharmacy Benefit Manager will receive from any pharmaceutical manufacturer for manufacturer administrative fees will be five and one half percent (5.5%) of the total Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of BCBSNM and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to Pharmacy Benefit Manager at BCBSNM's request.

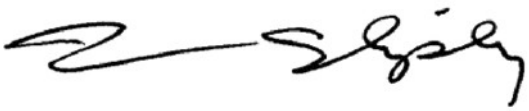
A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

This Pediatric Dental Care Rider contains information about the services and supplies for which Benefits will be provided. Please read the entire Rider very carefully. We hope that most of the questions you have about your coverage will be answered. If you have questions once you have read this Pediatric Dental Care Rider, call us at the number listed on the back of your Identification Card.

BCBSNM may change the Benefits described in this Pediatric Dental Care Rider. If that happens, BCBSNM will notify you of those changes.

Sincerely,



Kurt Shipley
President
Blue Cross and Blue Shield of New Mexico

THINGS YOU SHOULD KNOW

This Pediatric Dental Rider describes the Benefits available to Members under the age of 19. If after reading it, you still have questions, please contact BCBSNM Dental Customer Service.

Coverage under this Pediatric Dental Rider will continue at force at the option of you, the Member. However, BCBSNM may non- renew or discontinue coverage for an Eligible Member for the following reasons:

- Non- payment of premiums;
- Fraud;
- Termination of the particular type of coverage, or all coverage; or
- Relocation outside the geographic area (Network Service Area) designated by the Dental Plan.

SCHEDULE OF BENEFITS

A *Schedule of Benefits* is included with your member materials that shows the Benefit Period Maximum amount, Deductible requirements, and the percentage of the Allowable Charge that the Dental Plan will pay for a Covered Service. Members will receive a new *Schedule of Benefits* if changes are made to this Dental Plan.

LOOKING UP INFORMATION

This Pediatric Dental Rider is designed to make it easy for Members to determine their Benefits. For example, if you need to know the Benefit for an x-ray, turn to *Covered Services*. The *Diagnostic Radiographs* subsection defines the Benefits for an x-ray. The subsection also lists the most important limitations and exclusions to that particular service. *Limitations and Exclusions* lists other limitations and exclusions which **apply to all services, whether or not these items are listed separately within any subsection of the *Covered Services* section.**

CURRENT DENTAL TERMINOLOGY (CDT)

When classifying a certain dental service, BCBSNM Pediatric Dental Rider language reflects the most recent edition of a manual published by the American Dental Association entitled *Current Dental Terminology and Procedure Codes*. The Allowable Charge for a Covered Service will be based on the most inclusive code, determined by BCBSNM, in *Current Dental Terminology and Procedure Codes.* The Allowable Charge for a Covered Service will be based on the most recent edition of a manual published by the American Dental Association entitled *Current Dental Terminology and Procedure Codes*. (No Benefits will be provided for procedures which are components of a more inclusive code.) BCBSNM's dental processing procedures will be automatically updated as new codes are implemented by the American Dental Association.

CUSTOMER SERVICE

If you have any questions about your coverage, call a BCBSNM Dental Customer Advocate. For your convenience, the toll-free customer service numbers are printed at the bottom of every page in this Pediatric Dental Rider.

Dental Administrative Offices
P.O. Box 23090
Belleville, IL 62223-0090

Hours: 8:30 A.M. to 5:00 P.M. Central Time Monday-Friday
Phone number: 1-877-723-5697

HOW THIS DENTAL PLAN WORKS

BENEFIT PAYMENT FOR DENTAL SERVICES

This Dental Plan offers its Members freedom of choice and comprehensive coverage from BCBSNM. The services that a Dentist may perform depend upon what the Dentist is licensed or certified to do, and whether this Dental Plan recognizes the Dentist as eligible for payments.

Participating Dentist Network - BCBSNM Subscribers have access to thousands of Participating Dentists nationwide. Here's how using a Participating Dentist can benefit you:

- A Participating Dentist will file your Claims for you.
- Payment for Covered Services you receive will be sent directly to the Participating Dentist.
- You pay only the Deductible and/or Coinsurance amount (if any) that apply to your Covered Services. **If your Participating Dentist charges more than the Allowable Charge for Covered Services, you are not responsible for the difference.**

HOW YOUR DENTAL COVERAGE WORKS

This dental coverage is designed to give Subscribers some control over the cost of their own dental care. Subscribers continue to have complete freedom of choice as to the Dentist they wish to use. However, your coverage offers considerable financial advantages to Subscribers whenever they use a Participating Dentist.

This coverage operates around a group of Dentists who have agreed to charge no more than a reasonable, predetermined fee for their services. When Subscribers use these Participating Dentists, they will have less out-of-pocket expense. **In contrast, when care is received from an Out-of-Network Dentist, your coverage may be subject to a lower Benefit level.**

SELECTING A DENTIST

To locate a Participating Dentist, please call Customer Service at the number shown on your Identification Card. Before choosing a Dentist, you may want to check your *Dental Network Provider Directory* or visit the BCBSNM website at www.bcbsnm.com. If you do not have a current directory and would like a hard copy, contact BCBSNM Dental Customer Service for a list of Participating Dentists.

Although a directory is current as of the date published, it is subject to change without notice. To verify a Dentist's current status with your Dental Plan, contact a BCBSNM Dental Customer Advocate. Your Dentist choice - Participating or Out- of-Network - may make a difference in the amount you pay.

ALLOWABLE CHARGE

To take full advantage of the negotiated pricing arrangements in effect between BCBSNM and our network of Participating Dentists, you should use Participating Dentists whenever possible. Using a Participating Dentist offers the following advantages:

Participating Dentists have agreed to hold the line on dental care costs by providing special prices for our Subscribers. A Participating Dentist will accept this negotiated price (called the "**Allowable Charge**") as payment for Covered Service. This means that, if a Participating Dentist bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference.***

BCBSNM will calculate your Benefits based on this "Allowable Charge." We will deduct any charges for services which aren't eligible under your coverage, then subtract your Deductible or Coinsurance amounts which may be applicable to your Covered Dental Services. We will then

determine your Benefits under this Contract and direct any payment to your Participating Dentist.

If you use an Out-of-Network Dentist, you will be responsible for the following:

- Charges for any services which are not covered under this Dental Plan;
- Any Deductible and/or Coinsurance amounts which are applicable to your coverage; and
- The difference, if any, between the Dentist's "billed charges" and the Allowable Charge for Covered Services.

Your coverage may include a higher Deductible and/or Coinsurance percentage for services you receive from an Out-of-Network Provider (check the *Schedule of Benefits i*ssued with this Dental Plan).

BENEFIT PERIOD/POLICY YEAR

Some Benefits are limited to a specific dollar amount or number of services or visits allowed during a Benefit Period.

Your Benefit Period is a Calendar Year, which begins on your Effective Date. The initial Benefit Period is from your Effective Date of Coverage.

BENEFIT PERIOD MAXIMUM

The Benefit Period Maximum is the maximum dollar amount BCBSNM will pay for all Covered Services for each Subscriber during a Benefit Period according to the terms of this Benefit Booklet and the coverage outlined in the *Schedule of Benefits*. Each Subscriber's Benefit Period Maximum amount is given on the *Schedule of Benefits.*

DEDUCTIBLE REQUIREMENTS

The Deductible amounts for each Subscriber are shown on the *Schedule of Benefits.* The Deductible is the amount that each Subscriber must pay for Covered Services received during a Benefit Period before this Dental Plan begins paying its percentage of the Allowable Charge for Covered Services. The amount applied to the Deductible for a Covered Service cannot exceed the Allowable Charge for the Covered Service.

COINSURANCE PERCENTAGE

The Coinsurance percentage is the percentage of a covered charge that is your responsibility to pay for Covered Services. For Covered Services that are subject to Coinsurance, you pay the percentage (indicated on your *Schedule of Benefits*) of BCBSNM's covered charge after the Deductible, if required, has been met.

For each Covered Service, and after the Subscriber has met the Deductible (if applicable), this Dental Plan covers a certain percentage (specified on the Subscriber's *Schedule of Benefits*) of the Allowable Charge for the Covered Service. When a Covered Service is received from a Participating Provider, the Subscriber pays only the Deductible and/or Coinsurance amount applicable to that service. When a Covered Service is received from an Out-of-Network Provider, the Subscriber also is responsible for the amount charged by the Out-of-Network Provider that exceeds the Allowable Charge for the Covered Service.

OUT- OF- POCKET MAXIMUM

The Out- of- Pocket Maximum amounts for Subscribers are shown on the Schedule of Benefits. An Out- of- Pocket Maximum amount is the maximum amount of Deductible and Coinsurance that a Subscriber(s) pays for Covered Services received from a Participating Dentist during a Benefit Period.

Once an Out- of- Pocket Maximum is paid, this Dental Plan will begin paying 100 percent of any Covered Charges received by such Subscriber(s) from a Participating Dentist for the rest of that Benefit Period, not to exceed any applicable Benefit maximums.

CARE BY MORE THAN ONE DENTIST

Benefits will be provided to only one Dentist for any given Course of Treatment. There will be no duplication of Benefits due to a change of Dentists in the middle of a Course of Treatment.

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLANS

A Pretreatment Estimate is a determination by BCBSNM before you receive certain specified services that such services are Medically Necessary and/or in compliance with the provisions of this Dental Plan. It identifies this Dental Plan's **estimated** financial liability **before** treatment is started. Such estimates are subject to change, according to the terms of your coverage, and may include an allowance for alternate Benefits (see "Alternate Benefits'' later in this section).

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the Course of Treatment, copies of necessary x-rays, photographs and models, and an estimate of the charges prior to your beginning the Course of Treatment. BCBSNM will review the report and materials, taking into consideration alternative adequate Courses of Treatment, and will notify you and your Dentist of the estimated Benefits that will be provided (i.e. a "Pretreatment Estimate of Benefits"). This is **not** a guarantee of payment, but an estimate of the Benefits available for the proposed services to be rendered. BCBSNM's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Contract requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, you are responsible for asking the Dentist to submit another request and Course of Treatment, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by BCBSNM.

Mail the Pretreatment Estimate of Benefits requests and Course of Treatment forms to:

Blue Cross and Blue Shield of New Mexico
Dental Administrative Offices
P.O. Box 23090
Belleville, IL 62223-0090

ALTERNATE BENEFITS

If more than one Covered Service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment, as determined by BCBSNM. If you or your Dentist requests or you accept a more costly Covered Service, you are responsible for expenses that exceed the amount covered for the least costly service.

When two or more services are submitted and the services are considered part of the same service, the Plan will pay the most comprehensive service as determined by the Plan.

When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by the Plan.

BENEFIT PAYMENT FOR DENTAL SERVICES

The Benefits provided by BCBSNM and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Out- of- Network Dentist.

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield of New Mexico to accept the Allowable Charge as payment in full. Such Participating Dentists have agreed

not to bill you for Covered Service amounts in excess of the Allowable Charge. Therefore, you will be responsible only for any Coinsurance and/or Deductible amounts applicable to your Covered Services.

Out-of-Network Dentists are Dentists who have not signed an agreement with BCBSNM to accept the Allowable Charge as payment in full. Therefore, you are responsible to these Dentists for the difference between BCBSNM's Benefit and such Dentist's charge to you, in addition to any Coinsurance and/or Deductible amounts applicable to your services.

If you need to know the Allowable Charge for a particular procedure or whether a particular Dentist is a Participating Dentist, contact the Dentist or BCBSNM at the number listed on your Identification Card.

COVERED SERVICES

The Benefits in this section are subject to all the terms and conditions of this Dental Plan. Benefits are available only for services and supplies that are determined by a Provider, in consultation with BCBSNM to be Medically Necessary, unless otherwise specified. Such services and supplies for which Benefits are available include, but are not limited to the Covered Services that are listed in this section below. All Covered Services are subject to the *Limitations and Exclusions* section of this Benefit Booklet, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your *Schedule of Benefits* to find out what your Deductible, Coinsurance percentage, and any applicable Out- of- Pocket Maximum(s) will be for a Covered Service. If you do not have a *Schedule of Benefits*, please call Customer Service at the number shown on your Identification Card.

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or Physician. When the term Dentist is used in this Benefit Booklet, it will mean Dentist or Physician.

DIAGNOSTIC EVALUATIONS

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease. Covered Services include:

- periodic oral evaluations for established patients
- problem-focused oral evaluations, whether limited, detailed, or extensive
- comprehensive oral evaluations for new or established patients
- comprehensive periodontal evaluations for new or established patients
- oral evaluations of children under the age of three, including counseling with primary caregiver
- oral examinations – oral exams are limited to two every Benefit Period.

Special Provisions

- The combination of periodic routine and comprehensive evaluations are limited to **two** every **12 months.**
- The combination of problem-focused oral evaluations and comprehensive periodontal evaluations are limited to **two** every **12 months**.

PREVENTIVE SERVICES

Preventive services are performed to prevent dental disease. Covered Services include:

- Prophylaxis - Professional cleaning and polishing of the teeth. Benefits are limited to two cleanings every 12 months.
- Topical fluoride application - Benefits for fluoride application are only available for Participants under age 16 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

- Cleanings include associated scaling and polishing procedures.
- Following active periodontal treatment, Benefits are available for a combination of two prophylaxes, scaling in the presence of inflammation and two periodontal maintenance treatments (see *Non-Surgical Periodontic Services*) every 12 months.

DIAGNOSTIC RADIOGRAPHS (X-RAYS)

Dental radiographs, including interpretation, are x-rays taken to diagnose dental disease. Covered Services

include:

- full mouth (intraoral complete series) and panoramic films (Limited to a combined total of one every **60 months.)**
- bitewing films (Limited to **four** horizontal films or **eight** vertical films **once** every **12 months**.)
- intraoral periapical films, as necessary for diagnosis (Limited to six every **12 months.**)

MISCELLANEOUS PREVENTIVE SERVICES

Miscellaneous preventive services are other services used to prevent dental disease. Covered Services include:

- sealants for Members up to age **19** (Limited to **one** per tooth per **every 60 months**.)
- space maintainers for Members up to age **19**.

BASIC RESTORATIVE SERVICES

Basic restorative services are restorations necessary to repair basic dental decay (e.g. cavities), including tooth preparation, all adhesives, bases, liners, and polishing. Covered Services include:

- amalgam restorations (limited to **one** per tooth every **12 months** for Members up to age **19**)
- resin-based composite restorations (limited to **one** per tooth every **12 months** for Members up to age **19**).

NONSURGICAL EXTRACTIONS

Nonsurgical removal of tooth and tooth structures. Covered Services include:

- removal of retained coronal remnants – deciduous tooth
- removal of erupted tooth.

NONSURGICAL PERIODONTAL SERVICES

Nonsurgical periodontal services treat dental disease in the supporting and surrounding tissues of the teeth (gums). Covered Services include:

- periodontal scaling and root planing (Limited to **one** per quadrant every **24 months**.)
- scaling in the presence of generalized moderate to severe gingival inflammation is limited to once every 24 months.
- full mouth debridement to enable comprehensive periodontal evaluation and diagnosis (Limited to **one per lifetime**.)
- periodontal maintenance procedure (Must follow active periodontal treatment and are limited to **two** every **12 months** in combination with routine oral prophylaxes.)

ADJUNCTIVE GENERAL SERVICES

Covered Services include:

- emergency palliative treatment of dental pain (also called "palliative" treatment), but only when not performed in conjunction with a definitive treatment.

ENDODONTIC SERVICES

Endodontic services treat dental disease of the tooth pulp. Covered Services include:

- therapeutic pulpotomy and pulpal debridement when performed as a final endodontic procedure. These services are considered part of the root canal procedure if root canal therapy is performed within 45 days of services.
- root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care
- apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation, and hemisection.

ORAL SURGERY SERVICES

Oral surgery services means the procedures for surgical removal of tooth and tooth structures and other dental surgery under local anesthetics. Covered Services include:

- surgical tooth extractions
- alveoloplasty and vestibuloplasty
- excision of benign odontogenic tumor/cysts
- excision of bone tissue
- incision and drainage of intraoral abscess
- other Medically Necessary surgical and repair procedures not listed as an exclusion in this Plan.

Intraoral soft tissue incision and drainage is **only** covered when it is provided as the definitive treatment of an abscess. Routine post-operative care is considered part of the procedure.

SURGICAL PERIODONTAL SERVICES

Surgical periodontal services treat dental disease in the supporting and surrounding tissues of the teeth (gums) and supporting bone. Covered Services include:

- gingivectomy or gingivoplasty and gingival flap procedures - including root planing (Limited to **one** per quadrant **every 24 months**.)
- clinical crown lengthening
- osseous surgery, including flap entry with closure (Limited to one per quadrant every 24 months. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.)osseous grafts (Limited to one per site every 24 months.) Benefits are not available for bone grafts in conjunction with extractions, apicoectomy or any non- covered service or non-covered implants.
- soft tissue grafts/allografts (includes donor site) (Limited to **one** per site every **24 months**.)
- distal or proximal wedge procedure
- guided tissue regeneration (Limited to **once** per **36 months** up to age 19), and only when Medically Necessary
- bone grafts (Limited to **once** per **36 months**), and only when Medically Necessary.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered part of the restoration and no additional Benefits are provided for such periodontal services.

MAJOR RESTORATIVE SERVICES

Restorative services restore tooth structures lost as a result of dental decay or tooth fractures that

cannot be restored with amalgam or composite-type filing material. Covered Services include:

- single crown restorations
- inlay/onlay restorations
- labial veneer restorations.

Major restorations are limited to **one** per tooth every **60 months** whether placement was under this Dental Plan or under any prior dental coverage, even if the original crown was stainless steel.

PROSTHODONTIC SERVICES

Prosthodontic services restore and maintain the oral function, comfort, and health of a patient by replacing missing natural teeth with artificial substitutes. Covered Services include:

- complete and removable partial dentures (Benefits will be provided for the initial installation of removable complete, immediate, or partial dentures, including any adjustments, relines, or rebases during the six- month period following installation. Benefits for replacements are limited to **once** in any **60- month** period, whether placement was under this Dental Plan or under any prior coverage.)
- denture reline/rebase procedures (Limited to **one** in a **24** month period after the initial 6 month period following initial placement.)
- fixed bridgework (Benefits will be provided for the installation of bridgework (including inlays/onlays and crowns as retainers. Benefits are **limited to once every 60 months**.)

NOTE: Tissue conditioning is considered part of the procedure when performed on the same day as the delivery of a denture or a reline/rebase.

NOTE: An implant is a covered procedure of the Plan only if determined to be a dental necessity. Claim review for implant services are conducted by licensed Dentists who review the clinical documentation submitted by your treating Dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no Benefit will be allowed for the individual implant or implant procedure. Only the second phase of treatment (the prosthodontic phase-placement of the implant crown, bridge, or partial denture) may be subject to the alternate Benefit provision of the Plan.

- implant retained crowns, bridges, and dentures are subject to the alternate Benefit provision of the Plan.
- endosteal, eposteal, and transosteal implants- one every 60 months only if determined to be a dental necessity.

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services that are covered include:

- prefabricated crowns - stainless steel and resin (Limited to **one** per tooth every **60 months.** These crowns are not intended to be used as temporary crowns.)
- recementation of inlays/onlays, crowns, bridges, and post and core (Limited to two cementations every 12 months. Recementation provided within six months of initial placement done by the same Dentist is considered part of the procedure and no additional Benefits will be provided for such charges.)
- core build up, post and core, and prefabricated post and core are limited to 1 per tooth every 60 months
- crown and bridge repair services
- pulp cap - direct and indirect
- prosthodontic service adjustments (Limited to **three** times per Appliance every **12 months.**)

- repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (Limited to **once** per tooth or clasp **every 60 months**.)

MEDICALLY NECESSARY ORTHODONTIC SERVICES

Benefits for Medically Necessary orthodontic services are limited to Members who meet the Dental Plans criteria related to a medical condition including but are not limited to:

- cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services
- trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services
- skeletal anomaly involving maxillary and/or mandibular structures.

Benefits for Medically Necessary orthodontic procedures and treatment include examination records and tooth guidance and repositioning (straightening) of the teeth for Members covered for orthodontics, as shown on your *Schedule of Benefits*. Covered orthodontic services include:

- diagnostic orthodontic records and radiographs (Limited to a lifetime maximum of once per Member.)
- limited interceptive and comprehensive orthodontic treatment
- orthodontic retention (Limited to a lifetime maximum of one Appliance per Member.)

Special Provisions

- Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic Benefit. (See your *Schedule of Benefits* for more information.) Benefit payments cease when the Member is no longer covered, whether or not the entire Benefit has been paid out.
- Orthodontic treatment is started on the date the bands or Appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the maximum for orthodontic services. (See your *Schedule of Benefits* for more information.)
- If orthodontic treatment is terminated for any reason before completion of the orthodontic treatment plan, the Member is responsible for the remaining balance of treatment costs.
- For services in progress on the Effective Date of Coverage, Benefits will be **reduced** based on Benefits paid prior to this coverage beginning.

TMJ/CMJ SERVICES

This Plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders. Related orthodontic Appliances and treatment, crowns, bridges and dentures are covered only if the disorder is the result of trauma.

LIMITATIONS AND EXCLUSIONS

These general ***Limitations and Exclusions*** apply to all services described in this Benefit Booklet. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the *Definitions*) licensed to perform services covered under this Dental Plan.

Please note that in order to provide you with dental care Benefits at a reasonable cost, this Plan provides Benefits only for those Covered Services for eligible dental treatment that are determined by a Provider, in consultation with BCBSNM, to be Medically Necessary unless otherwise required by law.

No Benefits will be provided for procedures which are not Medically Necessary **unless otherwise required by law**. Medically Necessary generally means that a specific procedure provided to you is

required for the treatment or management of a dental symptom or condition and that the procedure is the most efficient and economical procedure which can safely be provided to you.

The fact that a Dentist may prescribe, order, recommend, or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

WHAT IS NOT COVERED:

No Benefits will be provided under this Dental Plan for the following:

1. Services or supplies when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Charge, as determined by BCBSNM.
3. Services and supplies for any illness or injury occurring on or after your coverage date as a result of war or an act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
4. Services or supplies that do not meet accepted standards of dental practice.
5. Investigational, Experimental, and/or Unproven services and supplies and all related services and supplies.
6. Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
7. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
8. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
9. Services rendered by a Dentist related to you by blood or marriage.
10. Services or supplies received from someone other than a Dentist, except for those services received from a licensed Dental Hygienist under the supervision and guidance of a Dentist, where applicable.
11. Claims for services which is for the same services performed on the same date for the same member.
12. Services or supplies received for behavior management or consultation purposes.
13. Services or supplies to the extent payment has been made under Medicare, or would have been made if you had applied for Medicare and claimed Medicare Benefits, or to the extent governmental units provide Benefits (some state or federal laws may affect how this exclusion is applied).
14. Charges for nutritional, tobacco, or oral hygiene counseling.
15. Charges for local, state, or territorial taxes on dental services or procedures.
16. Charges for the administration of infection control procedures as required by local, state, or federal mandates.
17. Charges for duplicate, temporary, or provisional prosthetic devices or other duplicate, temporary, or provisional Appliances.
18. Charges for telephone consultations, failure to keep a scheduled visit, completion of a Claim form, or forwarding requested records or x- rays.
19. Charges for prescription or nonprescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers.
20. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
21. Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth precision attachments for

partials and/or dentures and stress breakers.

22. Charges for partial or full denture or fixed bridge that includes replacement of a tooth that was missing prior to your Effective Date under this Dental Plan; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth that was extracted after your Effective Date.
23. Any services, treatments, or supplies covered under other hospital, medical and/or surgical coverage.
24. Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes including, but not limited to, bleaching teeth and grafts to improve aesthetics.
25. Case presentations or detailed and extensive treatment planning when billed separately.
26. Charges for occlusion analysis or occlusal adjustments.
27. Work- related conditions: Services or supplies for any illness or injury arising out of or in the course of employment for which Benefits are available under any Worker's Compensation Law or similar laws whether or not you make a claim for such compensation or receive such Benefits.
28. Orthodontic treatment that is not Medically Necessary.
29. Gold foil restorations.
30. Cone beam imaging and cone beam MRI procedures.
31. Sealants for teeth other than permanent molars.
32. Localized delivery of antimicrobial agents or chemotherapeutic agents.
33. Comprehensive periodontal evaluations or problem-focused evaluations if provided on the same date as any other oral evaluation by the same Dentist.
34. Tests and oral pathology procedures or for re-evaluations.
35. Bitewings taken on the same date as full mouth films.
36. Nutritional, tobacco, and oral hygiene counseling.
37. Local anesthesia that is not considered inclusive with the dental procedure.
38. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.
39. Endodontic therapy is not a Covered Service if you discontinue treatment.
40. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
41. Prophylactic removal of third molars or impacted teeth (i.e. removal of asymptomatic, nonpathological teeth), or for complete bony impactions covered by another dental plan.
42. Surgical services related to a congenital malformation.
43. Biologic materials to aid in tissue regeneration.
44. Restoration of occlusion or incisal edges due to bruxism (grinding or clenching teeth) or harmful habits or to correct attrition, abrasion, abfraction or erosion.
45. The replacement of a lost, missing or stolen Appliance and those for replacement of Appliances that have been damaged due to abuse, misuse, or neglect.
46. To alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other Appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
47. Replacement of complete or partial dentures due to theft, misplacement, or loss.

48. Treatment to replace teeth that were missing prior to the Effective Date of Coverage.
49. Congenitally missing teeth.
50. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
51. Recementation of an orthodontic Appliance by the same Dentist who placed the Appliance and/or who is responsible for the ongoing care of the Member.
52. Replacement or repair of an orthodontic Appliance.
53. Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

This Plan does not cover services resulting from work-related illness or injury. This exclusion from coverage applies to 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 charges for services resulting from a work-related illness or injury, **even if:**

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

Note: 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.)

CLAIM FILING PROCEDURES

PARTICIPATING DENTISTS

Participating Dentists have agreed to submit Claims directly to BCBSNM for you. When you receive Covered Services from a network Dentist, simply show your Identification Card, and Claims submission will be handled for you. If you must see an Out- of- Network Dentist who is not a member of BCBSNM's Participating Dentist Network, you may have to file a Claim yourself. If so, you should follow the guidelines below.

FILING DENTAL CLAIMS

In order to obtain your dental Benefits under this Dental Plan, it is necessary for a Claim to be filed with the Dental Plan. Usually all you have to do is show your BCBSNM Identification Card to your Dentist. They will file your Claim for you. Remember, however, it is your responsibility to ensure that the necessary Claim information has been provided to the Dental Plan.

If you use an Out-of-Network Dentist and have to file a Claim yourself, you may call Customer Service at the number on your Identification Card for a Claim form. As soon as treatment has ended, ask your Dentist to complete and sign the *Attending Dentist's Statement*. Once you complete the Claim form and attach the *Attending Dentist's Statement*, you may send the Claim to:

Blue Cross and Blue Shield of New Mexico
C/O Dental Network of America, Inc.
P.O. Box 23090
Belleville, IL 62223-0090

If a Dentist will not complete the *Attending Dentist's Statement* or does not bill BCBSNM directly, it is the Member's responsibility to attach itemized bills that include all necessary information to the Claim form and submit it to BCBSNM. Balance due statements, cash register receipts, and canceled checks are **not** acceptable.

TIMELY FILING LIMITS

Participating Dentists must file all Claims **within 180 days** after the date of service. Any Claims filed after this time limit may be denied, unless BCBSNM is satisfied that there is a valid reason why the Participating Dentist could not submit his/her Claim within this time limit. Members shall have **365** days (one year) after the date of service to file Member submitted Claims.

If a Claim must be returned to the Subscriber for additional information, the Claim must be resubmitted to BCBSNM **within 45 days** of the date the Claim was returned to the Subscriber.

If a Member's coverage under this Dental Plan ends, Claims for Covered Services incurred during the Member's final Benefit Period **must** be filed **within 180 days** after the date of the coverage termination. Failure to file a Claim **within the 180 days** will result in loss of Benefits otherwise provided by this Dental Plan if, as a result of such failure by the Member, BCBSNM is unable to perform adequate Claims review.

IF YOU HAVE OTHER VALID COVERAGE

If this Dental Plan is secondary to another plan, you need to file your claim with the other carrier first.

If a Dentist normally files Claims to BCBSNM and the other carrier does not pay the Dentist directly, the Dentist will need, from you, a copy of the other carrier's explanation of Benefits to include with the Claim sent to BCBSNM.

If an Out- of-Network Dentist does not file Claims for you, attach a copy of the Out- of-Network Dentist's explanation of Benefits to the Claim that you send to BCBSNM.

CLAIM FORMS AND ITEMIZED BILLS

All information on the Claim form and itemized statements must be readable. If information is missing on the Claim form or it is not readable, then BCBSNM will return it to the Subscriber or to the Dentist. **Handwritten entries added**

to a typed or computerized Claim form that change or add procedure codes are considered fraudulent and will require the Subscriber's and the Dentist's signatures acknowledging approval of such information.

The information on the itemized bills is used to determine Benefits, so it must support information reported on the submitted Claim form. All Claims must include:

- Subscriber's Dental Plan ID number
- Subscriber's name and address
- Member's name
- Member's age and relationship to the Subscriber
- other dental coverage in effect
- date of service
- type of treatment
- itemization of charges
- accident or surgery date (when applicable)
- name and address of Dentist
- Dentist's tax ID number or social security number
- Member's signature
- Dentist's signature

If an itemized bill from the Dentist is not attached to a Claim form, the Dentist must complete the "Dentist Information Section" and the "Examination and Treatment Record" of the *Attending Dentist's Statement* and **must** sign the Claim form.

Benefits cannot be determined if documentation is missing or radiographs submitted are not of sufficient diagnostic quality to determine Benefits.

Separate Claim Forms Required - A separate Claim form is required for each Dentist for which you are requesting reimbursement. A separate Claim form is also required for each Member when charges for more than one family member are being submitted.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim had been denied in whole or in part, you may ask for a review. The Dental Plan will review its decision in accordance with the procedure below.

If your Claim has been denied in whole or in part for lack of Medical Necessity, you may appeal the Dental Plan's decision.

You have 180 days following request of notification of an adverse benefit determination in which to appeal a decision to BCBSNM, however, you may exceed the 180- day limit when appealing to the Consumers Assistance Bureau of the Office of Superintendent of Insurance.

For an appeal to BCBSNM, send your request to:

Blue Cross and Blue Shield of New Mexico
Dental Administrative Office
P.O. Box 23100
Belleville, IL 62223-0100

For an appeal to the Consumers Assistance Bureau of the Office of Superintendent of Insurance, send your request to:

Office of Superintendent of Insurance Consumers Assistance Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689
Tel: 1- 855- 4ASK- OSI
1- 855- 427- 5674

You may also designate a representative to act for you in the review procedure. 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. While BCBSNM will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. BCBSNM will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claim procedures or the review procedure, you may call Customer Service at the number listed on your Identification Card. Or you can write:

Blue Cross and Blue Shield of New Mexico
Dental Administrative Office
P.O. Box 23060
Belleville, IL 62223-0060

If you have a Claim for Benefits which is denied, in whole or in part, you may file suit in a state or federal court.

DEFINITIONS

This section defines certain words used in this dental Benefit Booklet.

Allowable Charge — The charge that BCBSNM will use as the basis for Benefit determination for Covered Services incurred by a Member under this Dental Plan. BCBSNM will use the following criteria to establish the Allowable Charge for Covered Dental Services:

Participating Dentists - the amount the Dentist has agreed to accept as full payment for Covered Services.

Out- of- Network Dentists - the Dentist's usual charge, not to exceed the Out- of- Network Allowance.

Appliance - A device used to provide a function or a therapeutic effect (e.g., a denture).
Benefit Booklet - This document explains the Benefits, limitations, exclusions, terms, and conditions of this Dental Plan coverage and all endorsements, amendments, and riders attached hereto, now and in the future.

Benefit Period - The period of time during which you receive Covered Services for which BCBSNM will provide Benefits. The Benefit Period is a period of one year which begins on your Effective Date. When you first enroll under this dental coverage, your first Benefit Period begins on your Effective Date and ends on December 31 of the same year.

Benefit Period Maximum - The maximum dollar amount BCBSNM will pay for all Covered Services for each Member during a Benefit Period, according to the terms of this Benefit Booklet and the coverage outlined in the *Schedule of Benefits.* Each Member's Benefit Period Maximum amount is given on the *Schedule of Benefits*. Orthodontic services, if covered under this Dental Plan, do not apply to the Benefit Period Maximum.

Benefits - The payment and reimbursement of any kind which you will receive from BCBSNM under this Dental Plan.

Blue Cross and Blue Shield of New Mexico - 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 and /or the Plan.

Calendar Year - The period of 12 months commencing on the first day of January and ending on the last day of the following December.

Claim - Any request by a Subscriber for payment by an MHCP and/or any direct services provided to an individual. **Coinsurance** - The percentage of Allowable Charges for Covered Services for which the Member is responsible. **Contract** - This agreement, including the application and any amendments between you and BCBSNM.

Course of Treatment - Any number of dental procedures or treatments performed by a Provider in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

Covered Service - A service or supply provided in this Benefit Booklet and given by a Dentist for which we will provide Benefits.

Deductible - A specified amount of Covered Services that the Member must incur before BCBSNM will begin to pay its share of the remaining Covered Services.

Dental Plan - This Benefit Booklet, *Schedule of Benefits,* and your application for coverage under the Blue Cross and Blue Shield Dental Plan described in this booklet.

Dentist - A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

Eligible Members - Subscriber and family Members up to age 19.

Domestic Partner - A companion of the same or opposite sex with whom the Member has entered into a Domestic Partnership.

Domestic Partnership - A same- sex or opposite sex couple in a committed relationship, similar to a marriage, but without an official marriage license.

Effective Date - The date on which a Member's coverage under this Dental Plan begins.

Experimental, Investigational, or Unproven — A drug, device, biological product, or dental treatment or procedure is Experimental, Investigational, or Unproven if BCBSNM determines that:

- The drug, device, biological product, or dental treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or dental treatment or procedure is furnished;
- The drug, device, biological product, or dental treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- The prevailing opinion among peer reviewed dental and scientific literature regarding the drug, device, biological product, or dental treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Identification Card - The card BCBSNM gives to the Member which is used to confirm a Member's coverage. It may show such information as the Member's name, Member number, and plan number or name.

Medically Necessary (or Medical Necessity) - A specific procedure or supply provided to you is reasonably required in the judgement of a Provider, in consultation with BCBSNM, for the treatment or management of your specific dental symptom, injury, or condition and that the procedure performed is the most efficient and economical procedure that can safely be provided to you. The fact that a Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants retained by BCBSNM. These consultants review the Claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

Member - An Eligible person who has enrolled for coverage.

Network Service Area — The geographic area designated by BCBSNM, within which the Benefits of this Dental Plan are available to Members. A Member may call the Customer Service Department at the number shown on the Identification Card to determine if he or she is in the Network Service Area, or visit the website at www.bcbsnm.com.

Out- of-Network Allowance - The amount determined by BCBSNM as the maximum Provider charge eligible for Benefits. The Member will be responsible for the full amount by which the actual charges of an Out- of- Network Provider exceed the Out- of-Network Allowance.

Out- of- Network Dentist - A Dentist who has not entered into an agreement to be part of BCBSNM's Participating Dentist Network.

Out- of- Pocket Maximum - A specified amount of total Deductible and Coinsurance that a Member(s) must pay for Covered Services received from a Participating Dentist during a Benefit Period before BCBSNM begins to pay 100 percent of Allowable Charges for remaining Covered Services received by such Members(s) from a Participating Dentist during that Benefit Period, not to exceed any applicable Benefit Maximums.

Participating Dentist - A Dentist who has entered into an agreement to bill BCBSNM directly for Covered Services and to accept the Allowable Charge as payment for such Covered Services. Participating Dentists include the following:

- A Dentist who has entered into a Participating Provider Agreement with BCBSNM;
- A Dentist who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC);
- A Dentist who is a member of any other network with which HCSC or any of its subsidiaries has contracted.

Pediatric Orthodontic Services - Coverage is limited to Children under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe dysfunctional malocclusion).

Physician - A person who is a professional practitioner of a Healing Art defined and recognized by law and who holds a Physician license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or surgery or other procedures and provide services within the scope of such license.

Policy Year - The 12- month period beginning January 1 of each year.

Proof of Loss - A formal statement or Claim regarding a loss which provides sufficient information to allow BCBSNM to determine its liability for Covered Services. This includes a completed Claim form; the Dentist's itemized statement of services rendered, and related charges; and medical records, when requested by BCBSNM, as provided under the utilization review procedures of this Dental Plan.

Provider - A hospital, other facility, Dentist, Physician, or other health care Provider that BCBSNM recognizes as a dental care professional or medical facility. The Provider must be licensed, certified, or registered by the state or jurisdiction where services are provided to perform designated dental care services. Services of such a Provider must be among those covered by this Dental Plan and are subject to review by a dental authority appointed by BCBSNM. A professional supplier of dental supplies and equipment is considered an "other health care provider."

Subscriber - The person in whose name the Dental Plan coverage is established and to whom the Identification Card is issued.

Pediatric Dental

For Members under the age of 19

Blue Cross and Blue Shield of New Mexico

The following is a listing of common services available through your network of Participating Dentists.
The Member's share of the cost is determined by whether care is received from a Participating or Out-of-Network Dentist.
This information only provides highlights of the Pediatric Dental Plan. Please refer to the Pediatric Dental Rider for additional Benefit information.

In-Network Dental Benefits accumulate towards In-Network Medical Deductible and Out of Pocket Maximum and Out of Network Dental Benefits accumulate towards the Out of Network Medical Deductible and Out of Pocket Maximum.

SCHEDULE OF BENEFITS

Covered Services	Participating Dentist	Out-of-Network Dentist**
Diagnostic Evaluations	*30% after Medical Deductible*	*50% after Medical Deductible*
Preventive Services	*30% after Medical Deductible*[1]	*50% after Medical Deductible* [1]
Diagnostic Radiographs	*30% after Medical Deductible*	*50% after Medical Deductible*
Miscellaneous Preventive Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Basic Restorative Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Non-Surgical Extractions	*30% after Medical Deductible*	*50%, after Medical Deductible*
Non-Surgical Periodontal Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Adjunctive Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Endodontic Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Oral Surgery Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Surgical Periodontal Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Major Restorative Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Prosthodontic Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Miscellaneous Restorative and Prosthodontic Services	*30% after Medical Deductible*	*50%, after Medical Deductible*
Pediatric Orthodontic Services: Coverage limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe dysfunctional malocclusion) established by a Provider, in consultation with BCBSNM.	*30% after Medical Deductible*	*50%, after Medical Deductible*

1 Deductible is waived for fluoride treatments; after Deductible for all other preventive services.

** For Out-of-Network Dentist services, the Allowable Charge is the Provider's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. **The Member will be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.**

A Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Pediatric Vision Care Rider

Blue Cross and Blue Shield of New Mexico

This *Pediatric Vision Care Rider* is made part of, and is in addition to any information you may have in your Blue Cross and Blue Shield of New Mexico (BCBSNM) member benefit booklet. BCBSNM underwrites this *Pediatric Vision Care Rider* and has partnered with EyeMed Vision Care, LLC ("EyeMed"), also referred to as the "vision care plan administrator." EyeMed provides customer service and claims administration services to members enrolled in the pediatric vision care plan. The relationship between BCBSNM and EyeMed is that of independent contractors. Through our arrangement with EyeMed, you will have access to EyeMed's extensive network of vision care providers.

This *Pediatric Vision Care Rider* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical health care plan. **(Services that are covered under your medical/surgical plan are not covered under this *Pediatric Vision Care Rider*.) All provisions in the medical plan booklet apply to this *Pediatric Vision Care Rider* unless specifically indicated otherwise below.**

BY:

Kurtis Kossen, President, Retail Markets
Blue Cross and Blue Shield of New Mexico

This BCBSNM vision care plan allows members to select the provider of their choice, in or out of the network. BCBSNM has designed benefit plans to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through in-network services. You also have the flexibility to visit an out-of-network provider, with a reduction in benefits.

Definitions

Benefit Period – For purposes of this *Pediatric Vision Care Rider,* a period of time that begins on the later of: 1) the member's effective date of coverage under this *Pediatric Vision Care Rider,* or 2) the last date a vision examination was performed on the member or that vision materials were provided to the member, whichever is applicable. (A benefit period does not coincide with a calendar year and may differ for each covered member of a group or family.)

Medically Necessary Contact Lenses – Contact lenses may provide superior visual and physical results to spectacles in individuals with certain eye conditions. For purposes of this *Pediatric Vision Care Rider,* those conditions are limited to the following: keratoconus when the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses; high ametropia exceeding 12 D or +9 D in spherical equivalent; anisometropia of 3 D or more; patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Provider – For purposes of this *Pediatric Vision Care Rider,* a licensed ophthalmologist or optometrist operating within the scope of his or her license or a dispensing optician. An "in-network" provider is a provider who has contracted with the vision care plan administrator, EyeMed. An "out-of-network" provider has not contracted with EyeMed (even if such provider is contracted with BCBSNM to render covered services under your medical/surgical health care plan).

BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Vision Examination – A vision testing exam, including a determination as to the need for correction of visual acuity and prescribing lenses, if needed, that is performed by a licensed physician or optometrist who is operating within the scope of his/her license. A vision examination (including dilation, if necessary) includes but is not limited to the following:

- one eye exam every 12 months
- one pair of standard eyeglass lenses or contact lenses every 12 months
- one frame every 12 months
- minor repairs to eyeglasses
- lens tinting if certain conditions are present
- lenses to prevent double vision
- case history, including chief complaint and/or reason for visit, patient medical/eye health history, and record of current medications; record of visual acuities with/without present correction, if applicable
- pupil responses, external exam findings, internal exam findings, screening of visual fields perception
- diagnosis/prognosis and/or specific recommendations

Vision Materials – Corrective lenses and/or frames or contact lenses.

Eligibility

Children who are covered under a BCBSNM medical/surgical plan, up to age 19, are eligible for coverage under this *Pediatric Vision Care Rider*. NOTE: Once coverage is lost under the medical/surgical plan, all benefits cease under this *Pediatric Vision Care Rider.* Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available under this *Pediatric Vision Care Rider.*

Limitations and Exclusions

In addition to the general limitations and exclusions listed in your medical/surgical plan benefit booklet, this *Pediatric Vision Care Rider,* does not cover services or materials connected with or charges arising from:

- orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- aniseikonic lenses
- medical and/or surgical treatment of the eye, eyes, or supporting structures
- any eye or vision examination, or any corrective eye wear required by an employer as a condition of employment, and safety eyewear
- services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano nonprescription lenses or nonprescription sunglasses and/or contact lenses
- 2 pairs of glasses in lieu of bifocals
- services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
- services or materials provided by any other group benefit plan providing vision care; services covered under your medical/surgical plan
- replacement of lost, stolen, damaged, or broken materials, except in the next Benefit Frequency when Vision Materials would next become available, unless otherwise covered through warranty services of unlicensed personnel

How the Vision Care Plan Works

Under the vision care plan option, you may visit any covered provider and receive benefits for a vision examination. In order to maximize benefits for most covered vision materials, however, you must purchase them from an in-network provider. (An "in-network" provider is one who contracts with the vision care plan administrator, EyeMed, to provide services covered under this *Pediatric Vision Care Rider* to enrolled members. Providers who contract with BCBSNM are not considered "in-network" for purposes of this *Pediatric Vision Care Rider,* unless he/she also contracts with EyeMed.)

Before you go to an in-network vision care plan provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When you arrive, show the receptionist your BCBSNM health care plan or your vision plan identification card (the ID numbers should be the same). If you forget to take your card, be sure to say that you are a member of the BCBSNM vision care plan so that your eligibility can be verified.

To locate an in-network vision care provider, visit EyeMed's Web site at www.eyemed.com and use the Find a Provider link (choose the Select network for your search), or call 1-844-684-2257.

After you choose and order your eyeglasses or contacts from an in-network provider, your eyewear will be dispensed by the provider – generally within two to five business days from the date of the order. More delivery time may be needed for out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions, or when an in-network provider's frame that is not offered under EyeMed is selected. If you obtain glasses or contacts from an out-of-network provider, you must pay the provider in full and submit a claim to EyeMed for reimbursement (see "Claims Filing" for more information).

You may receive your eye examination and eyeglasses/contacts on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from one in- network provider and there may be additional professional charges if you seek contact lenses from a provider other than the one who performed your eye examination.

Fees charged for services other than a covered vision examination or covered vision materials, and amounts in excess of those payable under this *Pediatric Vision Care Rider,* must be paid in full by you to the provider, whether or not the provider participates in the vision care plan network. Benefits under this *Pediatric Vision Care Rider* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

Claims Filing and Appeal Procedures

In-Network Vision Services

When you receive vision services at an in-network vision plan provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of noncovered expenses (for example, vision perception training).

Claims for Out-of-Network Vision Services

When you receive covered vision services outside of the vision plan provider network, you will need to file a claim form. You can obtain a claim form from an EyeMed Member Services Representative or by accessing the website at www.eyemed.com. Be sure to fill out the claim form completely. You must submit your claim form no more than **90 calendar days** after the services were provided. If you choose to go to an out-of- network provider, please complete the following steps before submitting your claim form to EyeMed.

1. You are responsible for payment of vision care services at the time of service. BCBSNM (through the vision care plan administrator, EyeMed) will reimburse **you** for covered services. Please see the "Summary of Pediatric Vision Benefits," on the last page of this *Pediatric Vision Care Rider* for the list of qualified services and their reimbursement amounts.
2. Complete the Patient Information portion of your claim form.
3. Complete the Member/Employee Information Portion of your claim form. This information can be found on your ID card or by contacting your human resources or employee benefits department.
4. Complete the Provider Information portion of the form.
5. Sign the claim form. If the patient is a minor, the parent or legal guardian must sign the claim form.
6. Attach itemized receipts from your provider to the claim form. (Facsimiles and photocopies of bills cannot be accepted; please keep copies for your records. Bills will not be returned.) Please include the following breakdown of costs for each itemized bill:
   - Exam
   - Frames
   - Lenses (specific prescription and type of lenses)
   - Contact lenses (specific prescription and type of lenses)
7. Mail the claim form to the following address:

   First American Administrators
   Attn: OON Claims
   P.O. Box 8504
   Mason, OH 45040-7111

Customer Service

Questions about services covered under the vision care plan, in-network vision plan providers, or about benefits provided or denied under the plan can be directed to EyeMed seven days a week, Monday through Saturday 5:30 A.M. to 9:00 P.M., and Sunday 9:00 A.M. to 6:00 P.M. (Mountain Time) at 1-844-684-2257. An Interactive Voice Response unit is also available outside normal business operating hours. (Please direct member enrollment, termination, and other subscriber or dependent eligibility questions to BCBSNM—not to EyeMed.) Members using a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services through calling or using a TTY machine to engage an operator at 711 and asking the operator to call EyeMed at 1-844-230-6498.

If a claim for benefits is denied (in whole or in part), EyeMed will notify you in writing of the specific reasons for the denial, and of the process for requesting a review of the denial.

Member Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1-844-684-2257 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted below. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Appealing Denied Claims

If your claim is denied, in whole or in part, you may file an appeal. The appeal must be in writing and received by First American Administrators (FAA), a wholly-owned subsidiary of EyeMed, within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your appeal and notify you in writing of its decision.

For an appeal to the Consumers Assistance Bureau of the Office of Superintendent of Insurance, send your written letter of appeal to:

Office of Superintendent of Insurance
Consumers Assistance Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689

Summary of Pediatric Vision Benefits

	In-Network Benefits	Out-of-Network Benefits
Examination*	Member Copay	Member Copay
Eye Examination (with dilation as necessary)	No Charge	$30 (plan pays up to $30; member pays balance)
Eyeglass Benefit – Frame*		
Provider Designated Frames	Up to $100 (plan pays up to $100; member pays balance; 20% off balance over $100)	$50
Eyeglass Benefit – Spectacle Lenses*		
Clear plastic single-vision Lined bifocal Trifocal Lenticular lenses (any Rx)	No Charge	$25 $40 $55 $55
Contact Lens Benefit *		
Contact Lenses: Materials Allowance including Contact Lens Evaluation. Fitting and Follow-up Care is administered with a separate discount and not part of the evaluation. Routine eye exams do not include Fitting and Follow- up Care.	Up to $100 (plan pays up to $100; member pays balance)	$100 (plan pays up to $100; member pays balance)
Medically Necessary Contact Lenses ** Materials, Evaluation, Fitting & Follow-Up Care **See Medically Necessary definition on page 1 of this document.	No Charge	$210

Value-added feature:

In-network providers may offer discounts on the price of such noncovered services as Oversize Lenses, Tinting of Plastic Lenses, Scratch-Resistant Coating, Polycarbonate Lenses[2], Ultraviolet Coating, Standard Anti-Reflective (AR) Coating, Premier AR Coating, Ultra AR Coating, Standard Progressive Lenses[3], Premium Progressive (Varilux®, etc.), Intermediate-Vision Lenses, High-Index Lenses, Polarized Lenses, Plastic Photosensitive Lenses, Scratch Protection Plans for Single Vision and Multifocal Lenses, and Fittings and Follow-ups. Provider-designated[1] frames are covered in full with no charge. Conventional Contact Lenses are 15% off balance over $100. Check with your provider for more information. *Prices/discounts may vary by state and are subject to change without notice.*

* – Once every 12 months

1. – Provider Designated Frames are available at most participating independent provider offices. Provider Designated Frames are subject to change. Providers regularly update styles and brands of available children's eyewear.
2. – Polycarbonate lenses are covered in full, including for monocular patients and patients with prescription +/- 6.00 diopters or greater.
3. – Note: Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive lenses; however the cost of progressive lenses is not refundable.

Blue Cross and Blue Shield of New Mexico

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Endorsement:

2020 Benefit Booklet Changes for Retail HMO On and Off Exchange, Catastrophic HMO On and Off Exchange Plans, and Retail Pediatric Vison Riders.

This endorsement is for the retail Pediatric Vision Riders, and is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet.

EFFECTIVE DATE:

This endorsement is effective on January 1, 2020 or upon your group health plan's renewal date.

BY:

Kurt Shipley
President, Blue Cross and Blue Shield of New Mexico

Modification to Signature as shown below:

Found on "Message from Blue Cross and Blue Shield of NM and Page 1 of the Pediatric Vision Riders

BY:

Kurtis Kossen, President,
Retail Markets Blue Cross and Blue Shield of New Mexico

To be replaced by:

Found on "Message from Blue Cross and Blue Shield of NM and Page 1 of the Pediatric Vision Riders

BY:

Kurt Shipley, President
Blue Cross and Blue Shield of New Mexico

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

BlueCross BlueShield of New Mexico

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

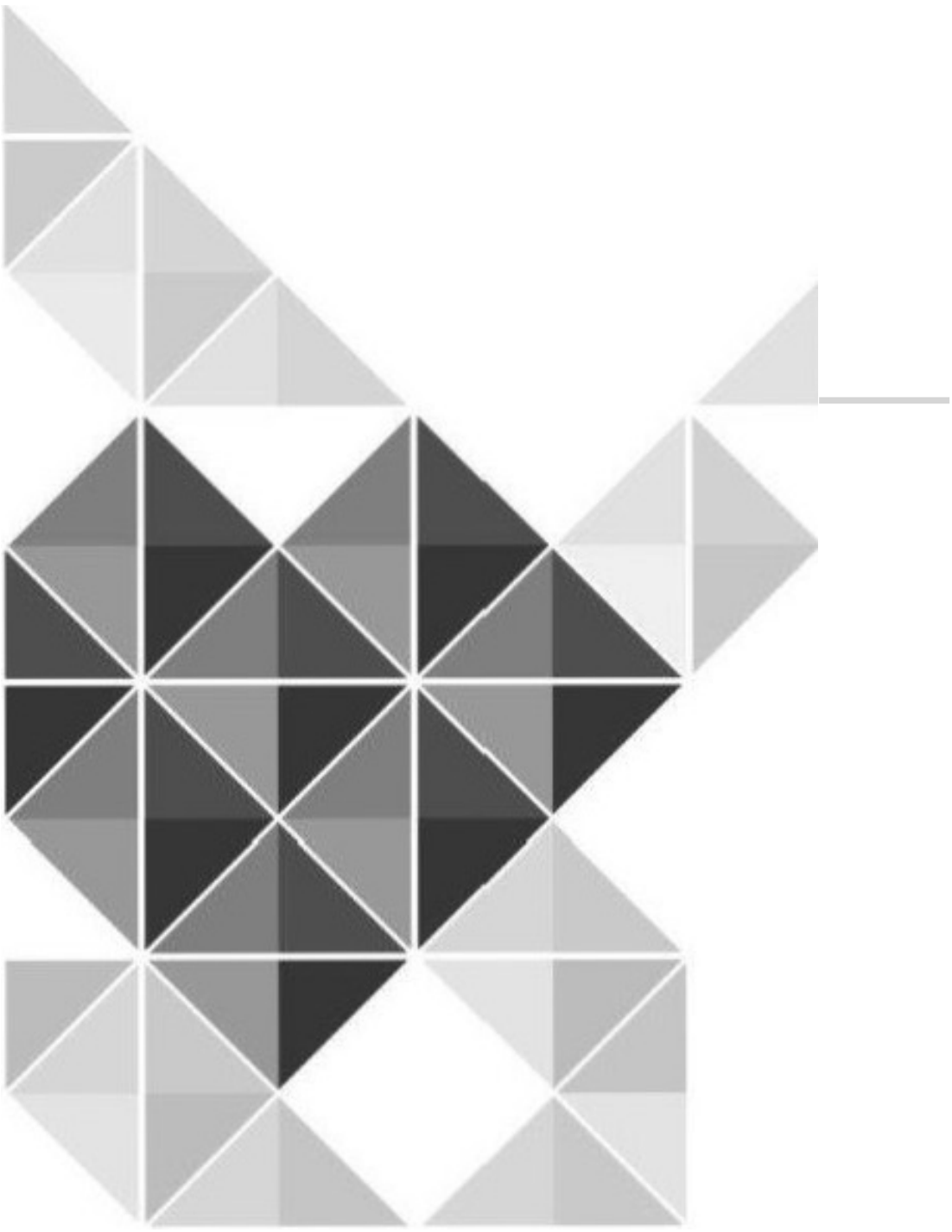
Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of New Mexico

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

Blue Cross Blue Shield
of New Mexico



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