BlueCross BlueShield of New Mexico

Your Health Care Benefits Program

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

TRIAD National Security, LLC

Account #: 113793

BluePPO Evolution℠

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

113793 (January 1, 2024)

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: 1-877-878-LANL (5265)

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

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

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

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

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

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

Send Claims* to:

Claims, Behavioral Health Unit
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

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

www.bcbsnm.com

To locate Preferred Providers throughout the United States and the world, visit the BlueCard Doctor and Hospital

***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: Claims Payments and Appeals* for details on submitting Claims.

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

A message from

TRIAD National Security, LLC

Welcome to the Medical Program for eligible employees and Non-Medicare-Eligible Retirees of **TRIAD National Security, LLC (TRIAD)** and their Eligible Family Members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **TRIAD** self-funded Health Care Benefit Plan. You will be accessing the Worldwide BCBS Preferred Provider network as if you were insured by BCBSNM.

This Medical Program is self-insured by **TRIAD**. This means **TRIAD** is responsible for the design of the Medical Program and the setting of contributions. **TRIAD** sets the employee contribution rates to be adequate to pay for the claims all **TRIAD** Medical Program Members incur. When claim costs exceed the contributions, the contribution rates have to go up. A small percentage of your contributions go towards the Medical Program administration costs (claims adjudication, customer service, Provider networking, ID Cards, booklet printing, etc.). The balance pays for the cost of your medical care.

In addition to this document, the **TRIAD** Health Benefit Plan for Employees (or for Retirees, if applicable) Summary Plan Description (**TRIAD** SPD) contains information about your **TRIAD** Medical Program. If any conflict should arise between this Benefit Booklet and the procedures of the Claims Administrator (BCBSNM) or if any provision is not explained or only partially explained in this document, the relevant **TRIAD** SPD will govern in all cases.

Every effort has been made to make this Benefit Booklet as accurate and easy to understand as possible. It is your responsibility to read and understand the terms and conditions in this booklet. We urge you to read it carefully and use it to make well-informed benefit decisions for you and your family.

If you have any questions once you have read this Benefit Booklet, call us at the number listed on the back of your ID Card, or as listed in *Customer Assistance* on the inside front cover. It is important to all of us that you understand the protection this coverage gives you.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and Independent Licensee of the Blue Cross Blue Shield Association is pleased to serve as Claims Administrator for the **TRIAD** Medical Program. You will be accessing the worldwide Blue Cross Blue shield Preferred Provider network as if you insured by BCBSNM.

Note: The Medical Program's benefit administrator and **TRIAD** may change the benefits described in this Benefit Booklet. If that happens, your benefits administrator or **TRIAD** will notify you of those mutually agreed upon changes.

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.

Sincerely,

TRIAD National Security, LLC

Note: This Medical Program is considered ungrandfathered, as a result Members have an additional appeal level regarding disputed claims and eligibility issues. See *Section 8* for more information about appeals.

This is a Preferred Provider (PPO) Medical Program. This means that if you obtain services from an Out-of-Network (Nonpreferred) Provider, your share of the bill is greatly increased. It is YOUR responsibility to determine if a Provider is in the national worldwide BCBS PPO network or not.

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

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

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

DEFINITIONS

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

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 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 DIRECTORY

Because this is a Preferred Provider (PPO) Medical Program, it is to your financial advantage to receive Covered Services from Providers that are within the worldwide BCBS Preferred Provider network. Since it is your responsibility to determine if a Provider is in the BCBS Preferred Provider network or not, BCBSNM has made every effort to assist you with finding a Preferred Provider-even while you are traveling. The Provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all Providers and their qualifications in the BCBSNM Preferred Provider (PPO) network and Participating Pharmacies. It also provides links to the listings of Preferred Providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although Provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a Provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com/lanl.

BLUECARD® BROCHURE

As a Member of a PPO Health Plan administered by BCBSNM, you take your Health Plan Benefits with you – across the country and around the world. The BlueCard Program gives you access to Preferred Providers almost everywhere you travel or live. Almost 90 percent of Physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your Eligible Family Members can receive the Preferred Provider level of benefits – even

when traveling or living outside New Mexico – by using Health Care Providers that contract as Preferred Providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your Health Care Plan coverage. Instructions for locating a Preferred Provider outside New Mexico are in the brochure or can be found on the BCBSNM website at www.bcbsnm.com.

OTHER BENEFIT RELATED MATERIALS

In addition to this Medical Program booklet you should have received (or have access to) a Summary Plan Description (SPD). You have on-line access to the SPD through Empyrean Customer Care, Your Benefit Resources web site at www.lanlbenefits.com. The **TRIAD** SPD provides a summary of the principal features of the entire **TRIAD** Health Benefit Plan for Retirees, ERISA Plan 502 (each called a "Plan"). The **TRIAD** SPDs provide summaries of all retiree benefits such as, but no limited to, life insurance, short-term disability, survivor benefits, etc. This Benefit Booklet is only one component of the **TRIAD** SPD and is referenced in Appendix C of the **TRIAD** SPD as Benefits Program Material of the Medical/Surgical Health Plan. This document provides a summary only for Medical Program benefits and exclusions, basic eligibility and enrollment requirement, cost-sharing features (such as Deductible and applicable Copayments), and administrative provision of the Claims Administrator (such as Prior Authorization requirements, coordination of benefits rules, appeal procedures, etc). The **TRIAD** SPD for your Benefit Program is available by contacting Empyrean Customer Care Center for LANL at (844) 805-0002.

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.

PRIOR AUTHORIZATION REQUIRED

To receive full benefits for some non-Emergency Admissions and certain Medical/Surgical Services, you or your Provider must call the BCBSNM Health Services department at (800) 325-8334 **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. See *Section 4: Utilization Management* for details. **Note:** Call Customer Service if you need Prior Authorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive full benefits for Emergency Hospital Admissions, you (or your Provider) should notify BCBSNM **within 48 hours** of Admission, or as soon as reasonably possible following Admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain 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 Prior Authorization before you are discharged.

Written Request Required

If a **written request** for Prior Authorization is required in order for a service to be covered, you or your Provider should send the request, along with appropriate documentation, to:

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

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

PRIOR AUTHORIZATION OF BEHAVIORAL HEALTH CARE

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

condition makes it impossible to call within 48 hours, as soon as possible. The BHU will coordinate Covered Services with an In-Network Provider near you. **If you do not call and receive Prior Authorization before receiving non-Emergency services, benefits for services may be denied**. Call 7 days a week, 24 hours a day:

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

PRIOR AUTHORIZATION AND COMPLAINT/APPEAL PROCEDURES

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

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

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

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse status and unless otherwise permitted by law. 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.

TELEMEDICINE MEDICAL SERVICES

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

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

CUSTOMER SERVICE

If you have any questions about your coverage, call or e-mail BCBSNM's Customer Service department. The Customer Services number is listed at the bottom of the page. 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 P.M. the next business day.

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with Prior Authorization requests
- check on a Claims status

- order a replacement ID Card, Provider directory, Benefit Booklet, or forms

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

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

Website: www.bcbsnm.com

Behavioral Health Customer Service

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

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

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

Translation Assistance

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

After Hours Help

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

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

24/7 Nurseline

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

Toll-free: 1-800-973-6329

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

BLUE ACCESS FOR MEMBERS[SM]

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

If you need help accessing the BAM site, call:

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

OTHER TRIAD PROGRAM ASSISTANCE

For questions about eligibility, enrollment, termination, and continuation of Medical Program coverage, for information about switching Medical Programs or adding or cancelling a family member's coverage, contact:

	For Employees:	For Retirees:
Customer Service	Los Alamos National Laboratory (LANL) LANL Benefits Office PO Box 1663, Mail Stop P280 Los Alamos, NM 87544	Empyrean Customer Care Center (844) 805-0002
Phone Number	(877) 667-1806 or (505) 667-1806	Empyrean Customer Care Center (844) 805-0002
E-Mail Address	benefits@lanl.gov	
Web Site	http://int.lanl.gov/employees/benefits/index.shtml	https://ess5.empyreanbenefitsolutions.com/lans/login

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.

ELIGIBILITY

Please refer to the applicable **TRIAD** Health Benefit Plan Summary Plan Description for enrollment, eligibility, termination, and Plan Administration information including details about continuation of Group coverage under COBRA and USERRA.

SECTION 2: 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 Administrative Services Agreement
- 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 an 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 Medical Program. **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 Medical Program was discontinued for the entire Group or the employee's enrollment classification
- when you reside outside of or move out of New Mexico (Call BCBSNM for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where you are living.)

If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. (The options for Members under age 65 are limited.) Call a Customer Service Advocate for 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 Medical Program are not available under conversion coverage.) Contact a Customer Service Advocate for details.

SECTION 3: HOW YOUR PLAN WORKS

BENEFIT CHOICES

This Health Care Plan is a Preferred Provider Option (PPO) Health Care Plan that gives you the opportunity to save money, while providing you choice and flexibility when you need medical/surgical care and Preventive Services. When you need health care, you have the choice of obtaining benefits from either a Preferred Provider or a Nonpreferred Provider. It's important to understand the differences between them. When you receive treatment or schedule a surgery or Admission, ask each of your Providers if he/she is a BCBSNM Preferred Provider. (A Physician's or Other Provider's contract may be separate from the Facility's contract.) Your choice can make a difference in the amount you pay and the benefits available to you.

Your Choices

	Preferred Provider Services	**Nonpreferred Provider Services**
Cost-Sharing Differences	You pay either a fixed-dollar Copayment amount (which is usually not subject to the annual Deductible) or you pay a Deductible and a percentage of Covered Charges after the Deductible is met.	You must meet a higher Deducible amount, pay a higher percentage of Covered Charges, and meet a higher Out-of-Pocket Limit. Note: Transplants are not covered if received from a Non-Contracted Provider or Facility.
Covered Charge vs. Billed Amount	If the Covered Charge is less than the billed amount, the Preferred Provider will write off the difference. You pay only applicable Copayments, Coinsurance, non-covered expenses, and penalty amounts, if any.	The Nonpreferred Provider may bill you for amounts over the Covered Charge. BCBSNM also will not pay the Nonpreferred Provider directly, so you will be responsible for arranging to pay the entire billed amount to the Provider.
Filing Claims	The Preferred Provider is responsible for filing claims directly to the local BCBS Plan. The Provider will ask for your ID Card, for your signature, for information about other coverage, etc. so that the Provider may file a claim for you. The Provider will be paid directly by BCBSNM.	You may have to pay the Nonpreferred Provider in full and submit your own claims; the decision is up to the Provider. If you file the claim, you must send the itemized bill for Covered Services to BCBSNM, attached to a Member claim form, within 12 months of receiving the service. If you do not meet the time limit for filing claims, the claim will be denied.
Requesting Prior Authorizations	Preferred Providers that contract directly with BCBSNM are responsible for requesting all necessary Prior Authorizations on your behalf. (Providers that contract with another BCBS Plan (i.e., BCBS of Texas) may call for Prior Authorization on your behalf, but you will be responsible for making sure that Prior Authorization is obtained when required.)	Nonpreferred Providers may call for Prior Authorizations on your behalf, but you are responsible for making sure that all Prior Authorizations are obtained when required. If Prior Authorization is not obtained, you may have to pay an additional penalty, or the services may be denied completely.
Available Benefits	All services covered under this Medical Program are eligible for coverage at the Preferred Provider benefit level. (Specialist cost-sharing provisions apply to certain Transplants.)	Some benefits are not available unless services are received from a Preferred Provider. See the *Summary of Benefits* for a list of services not covered at the Nonpreferred Provider benefit level, if applicable.

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

Although you can go to the Hospital or Physician of your choice, benefits under the PPO program will be greater when you use the services of a Preferred Provider.

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

Preferred Providers (In-Network) are Health Care Professionals and Facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as "Preferred" or "PPO" Providers. These Providers have agreed to provide health care for PPO plan Members and accept the Medical Program's payment for a Covered Service plus the Member's share of the Covered Charge (i.e., Deductible, Coinsurance, Copayment, and or penalty amounts if any) as payment in full.

Nonpreferred Providers (Out-of-Network) 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 (In-Network). A "Participating" Provider is a Provider that falls under Out-of-Network benefit, however this Provider agrees to a Covered Charge and will not Balance Bill the Member for amounts above the Covered Charge. See *Section 8: Claims Payments and Appeals* for more information.)

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.)

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

PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

When you need medical care, there are a variety of ways you can choose a Preferred Provider in your area. You can also access Mental Disorder Providers (including those specializing in Chemical Dependency) and Participating Pharmacies.

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.

Note: Providers who are listed in the directory as having a "Participating" contract are **not** "Preferred" Providers (unless they are also listed as having a "Preferred" Provider contract). **You will not receive the "Preferred Provider" benefit level when receiving services from a "Participating" Network Provider.** You must use Providers in the **"Preferred" Provider network** in order to obtain the highest level of benefit under this Medical Program for non-Emergency Care. However, if you live in or travel to a state that does not offer Preferred Provider contracts, you can receive the "Preferred Provider" benefit level by visiting "Participating" Providers in that state. **If you are in an Emergency situation, call 911 if necessary or go directly to the nearest Emergency Room.**

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

Web-Based BCBSNM Provider Finder

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

www.bcbsnm.com

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

Paper Provider Network Directory

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

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, listed on the *Summary of Benefits.* **Note:** Providers who have a "Participating-only" contract are **not** Preferred Providers and you will not receive the Preferred Provider benefit level when receiving services from Participating-only Providers. You must use **Preferred Providers** in order to obtain the higher benefit (unless listed under **"Benefit Level Exceptions,"** later in this section).

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

BCBSNM Website

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

BCBSNM website: www.bcbsnm.com

National Website

Visit the Blue Cross and Blue Shield Association website at www.bcbs.com and click on the national "BlueCard Doctor and Hospital Finder," then select "Find a Doctor or Hospital." Follow the instructions.

Blue Cross and Blue Shield Association website:

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

National Phone Number

Call BlueCard Access® at the phone number below for the names and addresses of Doctors and Hospitals in the area where you or an Eligible Family Member need care. When you call, a BlueCard representative will give you the name and telephone number of a local Provider (you will be asked for the zip code in the area of your search) who will be able to call Customer Service for eligibility information and will submit a Claim for the services provided to the local BCBS Plan. Call:

1-800-810-BLUE (2583)

International Assistance

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

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

Members who extend coverage under an extension of benefits due to disability are not eligible to receive Prior Authorization for services of an Out-of-Network Provider. Services of an Out-of-Network Provider are **not** covered in such instances of extended coverage.

CALENDAR YEAR

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

BENEFIT LIMITS

There is no general lifetime maximum benefit under this Medical Program. 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

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

YOUR DEDUCTIBLE

Your Deductible is the amount of Covered Charges that you must pay in a Calendar Year before this Medical Program begins to pay its share of the applicable (Preferred or Nonpreferred Provider) Covered Charges you incur during the same Calendar Year. If the Deductible amount remains the same during the Calendar Year, you pay it only once each Calendar Year, and it applies to all Preferred or Nonpreferred Provider Covered Services you receive during that Calendar Year.

Covered Charges for Preferred Provider services are **not** applied to the Nonpreferred Provider Deductible and Covered Charges for Nonpreferred Providers are **not** applied to the Preferred Provider Deductible.

Individual Deductible

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

Family Deductible

An entire family meets the applicable annual Deductible when the total Deductible amount for all family members reaches the amount specified on your separately issued *Summary of Benefits.* **Note:** If a Member's Individual Deductible is met, no more charges incurred by that Member may be used to satisfy the applicable Family Deductible.

Embedded Deductible

When one family member meets the “Individual Coverage” Deductible, that family member does not have to wait until the higher “Family Coverage” Deductible is met before benefits apply.

The Deductible amount you must satisfy depends on whether you have Individual or Family coverage. An Individual Coverage Member must meet the “Individual Coverage” Deductible before this Medical Program begins to pay your Covered Charges.

What Is Not Subject to the Deductible

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

- In-Network Preventive Services
- fixed dollar Copayments

Admissions Spanning Two Calendar Years

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

Timely Filing Reminder

Most benefits are payable only after BCBSNM's records show that the applicable Deductible has been met. Preferred Providers and Providers that have "Participating-only" Provider agreements with BCBSNM will file Claims for you and must submit them within a specified amount of time (usually 180 days). If you file your own Claims for Covered Services from Nonparticipating Providers, you must file them **within 12 months** of the date of service. If a Claim is returned for further information, resubmit it **within 45 days.** See *Section 8: Claims Payments and Appeals* for details.

COPAYMENTS

The fixed-dollar amount of a Covered Charge that you pay for some Covered Services such as, but not necessarily limited to: office, Emergency Room, and Urgent Care Facility visits from Preferred Providers and for Residential Treatment Center care. (Other services received during the visit may be subject to Deductible and/or Coinsurance; see the *Summary of Benefits*.)

Copayments are the fixed-dollar amount of a Covered Charge that you pay for certain services as specified on the separately issued *Summary of Benefits*.

Office Visit Copayment

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

Besides office visits, other services are also subject to a Copayment amount. See the *Summary of Benefits*.

Primary Preferred Provider (PPP) is a Preferred Provider in one of the following medical specialties **only**: Family Practice; General Practice; Oriental Medicine; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include Physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

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

COINSURANCE

For some Covered Services, received from a Preferred Providers, you must pay a percentage of Covered Charges (Coinsurance) after you have met your annual Deductible. After your share has been calculated, this Medical Program pays the rest of the Covered Charge, up to maximum benefit limits, if any. You pay a lower percentage of Covered Charges when you visit a Preferred Provider.

For some Covered Services, you must pay a percentage of Covered Charges as "Coinsurance." After your share has been calculated, this Medical Program pays the rest of the Covered Charge, up to maximum benefit limits, if any.

Nonpreferred Providers may charge you the difference between the billed charge for a Covered Service and the Covered Charge allowed by BCBSNM – in addition to your Coinsurance and Deductible amount.

Remember: The Covered Charge may be less than the billed charge for a Covered Service. Preferred Providers may not bill you more than the Covered Charge. **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.

Preferred Providers

When you receive Covered Services from a Preferred Provider, you pay an annual Deductible. Preferred Provider office visit charges are not subject to the Coinsurance or Deductible unless listed as otherwise on your summary.

Nonpreferred Providers

When you receive Covered Services from a Nonpreferred Provider, you must pay an annual Deductible and a percentage of Covered Charges. If the Covered Charge is less than the billed charge, you will also be responsible for paying the difference when you receive services from a Nonpreferred Provider. See *Section 8: Claims Payments and Appeals,* "Provider Payment Example," for more information.

OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit is the maximum amount of Deductible, Coinsurance, and Copayments that you pay for most Covered Services in a Calendar Year. There are separate Out-of-Pocket Limits for Preferred Providers and Nonpreferred Providers. After the Out-of-Pocket Limit is reached, this Medical Program pays 100 percent of most of your Preferred Provider or Nonpreferred Provider Covered Charges for the rest of the Calendar Year, not to exceed any benefit limits.

The Out-of-Pocket amounts for Preferred Provider services are **not** applied to the Nonpreferred Provider Out-of- Pocket Limit. In addition, the Out-of-Pocket amounts for Nonpreferred Provider services are **not** applied to the Preferred Provider Out-of-Pocket Limit.

Individual Limits

Once your Coinsurance, Deductible, amounts for Preferred Provider (In-Network Provider) services in a Calendar Year reaches the individual Preferred Provider amount indicated on the *Summary of Benefits,* this Medical Program pays 100 percent of most of your covered Preferred Provider charges (excludes inpatient Hospital Copayment, services in excess of annual or lifetime limits and Residential Treatment Center Copayment) for the rest of the Calendar Year.

Once your Coinsurance amounts for Nonpreferred Provider services (Out-of-Network) in a Calendar Year reaches the higher individual Nonpreferred Provider amount indicated on the *Summary of Benefits*, this Medical Program pays 100 percent of most of your covered Nonpreferred Provider charges (excludes inpatient Hospital Copayment, services in excess of annual or lifetime limits and Residential Treatment Center Copayment) for the rest of the Calendar Year.

Family Limits

An entire family meets the Out-of-Pocket Limit when the total Deductible, Coinsurance and Copayments for all family members reaches the amount specified in the *Summary of Benefits*. (When a Member meets the Individual Out-of-Pocket Limit, no more charges incurred by that Member may be used to satisfy the applicable Family Out-of-Pocket Limit.).

What Is Not Included in the Out-of-Pocket Limits

The following amounts are **not** applied to the Out-of-Pocket Limits and are **not** eligible for 100 percent payment under this provision:

- penalty amounts

- non-Covered expenses (including services in excess of annual or lifetime day/visit limits)
- amounts in excess of Covered Charges (including amounts in excess of annual or lifetime benefit limits, if applicable)

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

CHANGES TO THE COST-SHARING AMOUNTS

Copayments, Coinsurance percentage amounts, Deductibles, and Out-of-Pocket Limits may change during a Calendar Year. If changes are made, the change applies only to services received after the change goes into effect (for Inpatient Services, benefits are determined based on the date you are admitted to the Facility). You will be notified if changes are made to this Medical Program.

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.

BENEFIT LEVEL EXCEPTIONS

Benefits will be provided as indicated on the *Summary of Benefits*, except as listed below.

Emergency Care

If you visit a Nonpreferred Provider (Out-of-Network) for Emergency Care services, the Preferred Provider (In-Network) Deductible and Coinsurance 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. (Office/Urgent Care Facility services are not considered "Emergency Care" for purposes of this provision.) Non-Emergency services provided in an emergency room for treatment of Mental Disorders or Chemical Dependency will be paid the same as Emergency Care services.

Except in emergencies, BCBSNM will generally NOT authorize services of a Nonpreferred Provider if the services could be obtained from a Preferred Provider. Authorizations for such services are given only under very special circumstances related to medically necessity and lack of Provider availability in the Preferred Provider network. BCBSNM will NOT authorize any such request based on non-medical issues such as whether or not you or your doctor prefer the Nonpreferred (Out-of-Network) Provider or find the Provider more convenient. If a preferred (In-Network) Provider is available in another city, you may have to travel to that city to receive benefits for non-Emergency Care.

For follow-up care (which is no longer considered Emergency Care) and for all other non-Emergency Care, you will receive the Nonpreferred Provider (Out-of-Network) benefit for the services of a Nonpreferred Provider (In-Network), even if a Preferred Provider is not available to perform the service, except as specified below. (See "Emergency and Urgent Care" in *Section 5: Covered Services* for more information.)

Transition of Care

This provision applies to both Continuity of Care and Transition of Care. If your Health Care Provider leaves the BCBSNM Provider network (for reasons other than medical competence or professional behavior) or if you are a new Member and your Provider is not in the Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the Provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating Provider, BCBSNM may also authorize transitional care from other Out-of-Network Providers.) An ongoing course of treatment will include, but is not limited to: (1) Treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) Treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as Chemotherapy, Radiation Therapy or post-operative visits; (3) The second or third trimester of Pregnancy, through the postpartum

period; or (4) An ongoing course of treatment for a health condition for which a treating Physician or Health Care Provider attests that discontinuing care by that Physician or Health Care Provider would worsen the condition or interfere with anticipated outcomes. The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. Call the BCBSNM Customer Service department for details.

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

Unsolicited Providers

In some states, the local BCBS Plan does not offer Preferred Provider contracts to certain types of Providers (e.g., Home Health Care Agencies, Chiropractors, Ambulance Providers). These Provider types are referred to as "unsolicited Providers." Unsolicited Providers vary from state to state. If you receive Covered Services from an "unsolicited Provider" outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, 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. Note: Christian Science Practitioners and Sanatoriums are not considered unsolicited under this provision and you will receive benefits based solely on whether or not the Provider in question has a Preferred Provider contract with the local BCBS Plan.

Ancillary Provider

Once you have obtained Prior Authorization for an inpatient Admission to a Preferred Hospital or Treatment Facility, your Preferred Physician or Hospital will make every effort to ensure that you receive ancillary services from other Preferred Providers. If you receive Covered Services from a **Preferred** Physician for Outpatient Surgery or inpatient medical/surgical care in a Preferred Hospital or Treatment Facility, services of a Nonpreferred radiologist, anesthesiologist, or pathologist will be paid at the Preferred Provider level and you will not be responsible for any amounts over the Covered Charge (these are the only three specialties covered under this provision).

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

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

SECTION 4: UTILIZATION MANAGEMENT

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on BCBSNM medical policy and site or level of care review criteria. Medical Necessity reviews may occur when a Provider requests an authorization prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be review for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

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

PRIOR AUTHORIZATION

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

In order to receive benefits:

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

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

Medically Necessary/Medical Necessity is defined as Health Care Services determined by a Provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or Mental Disorder condition, illness, injury, or disease.

Please note:

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

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

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

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

HOW THE PRIOR AUTHORIZATION PROCEDURE WORKS

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

BCBSNM PREFERRED PROVIDERS

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

- when recommending any non-Emergency Admission, re-Admission, or transfer
- when a covered newborn stays in the Hospital longer than the mother
- before providing or recommending a service listed under "Other Prior Authorizations," later in this section
- before recommending that you go to a Provider for whose services you expect to receive benefits (Such requests may be denied.)

Note: Providers that contract with other Blue Cross and Blue Shield plans are not familiar with the Prior Authorization requirements of BCBSNM. Unless a Provider contracts directly with BCBSNM as a Preferred Provider, the Provider is not responsible for being aware of this Medical Program's Prior Authorization 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 Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, your benefits for Covered Services may be denied for some services or you may be entirely responsible for the charges. The Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is called.

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 PRIOR AUTHORIZATION

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

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

NOT OBTAINING INPATIENT PRIOR AUTHORIZATION

If you or your Provider do not receive Prior Authorization for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid as indicated in the table below:

If, based on a review of the Claim:	Then:
The Admission was not for a Covered Service.	Benefits for the Facility and all related services will be denied.*
The Admission was for an item listed under "Other Prior Authorizations," (e.g., elective Admissions).	Benefits for the Facility and all related services may be denied.*
The Admission was for any other Covered Service but hospitalization was not Medically Necessary.	Benefits may be denied for room, board, and other charges that are not Medically Necessary.*
The Admission was for a Medically Necessary Covered Service.	Benefits for the Facility's Covered Services may be denied or reduced by $300.*

*The Admission review penalty of $300 and charges for non-covered and denied services are not applied to any Deductible or Out-of-Pocket limit. You are responsible for paying this amount for Out-of-Network services.

Inpatient Prior Authorization requirements may affect the amounts that this Medical Program pays for Inpatient Services, but they do not deny your right to be admitted to any Facility and to choose your services.

OTHER PRIOR AUTHORIZATIONS

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

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

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

Services that require Prior Authorization:

- Non-Emergency Air Ambulance transportation
- All inpatient Hospital Admissions
- The following Outpatient Services and procedures:
  - — Home Health Care
  - — Home infusion therapy (HIT), excluding antibiotics
  - — Home Hospice
  - — Outpatient surgery performed at a Hospital or Ambulatory Surgical Facility for Out-of-Network services only
  - — Transplant Evaluations and Transplants

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

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

— **Neurology:**
  - Deep Brain Stimulation
  - Sacral Nerve Neuromodulation/Stimulation

— **Specialty Pharmacy:**
  - Specialty Pharmacy Medications covered by Medical Benefits including Infusion Site of Care, Medical Oncology & Supportive Care and Provider Administered Drug Therapies

— **Surgical Procedures:**
  - Outpatient Surgery Jaw
  - Outpatient Breast
  - Surgical Deactivation of Headache Trigger Sites

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

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

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

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

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

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

PRIOR AUTHORIZATION OF MENTAL DISORDER/CHEMICAL DEPENDENCY SERVICES

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

- Psychological OR Neuropsychological testing in some cases (Blue Cross Blue Shield will notify your Provider if Prior Authorization is required)
- Intensive Outpatient Program (IOP) Treatment
- Electroconvulsive Therapy (ECT)
- Repetitive Transcranial Magnetic Stimulation
- Applied Behavioral Analysis (ABA) Therapies

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

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

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

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

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

Summary of Contact Information for Prior Authorization, Customer Service, Claim Submission and Appeal (or Reconsideration) Processes for Medical/Surgical and Mental Disorders/Chemical Dependency Services:			
Process:	**Type of Service:**	**Phone:**	**Send to:**
Request Prior Authorization	Medical/Surgical	1-800-325-8334	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/ABA/Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630

Customer Service Inquiry	Medical/Surgical	1-877-878-lanl (5265)	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/ABA/Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Submit Claim (post-service)	Medical/Surgical	1-877-878-lanl (5265)	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/ABA/Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Request appeal of Claim or Prior Authorization decision	Medical/Surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/ABA/Chemical Dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630

DISEASE MANAGEMENT

If you are living with a long term health condition, you may have a hard time managing your health on a day-to-day basis. Help is available with disease management programs offered by BCBSNM. These programs, which you do not have to participate in if you don't want to, are for Members with diabetes, heart conditions, asthma, low back pain, migraine headaches, and lung disease. BCBSNM will try to identify Members who could use these programs, but you can also enroll yourself. If you are enrolled, you will be called by a Blue Care Advisor, a nurse that will identify your needs and work with you and your doctors.

CASE MANAGEMENT

When BCBSNM helps you, your doctor, and Other Providers plan for major services, it is called case management. When you have a need for many long term services or services for more than on condition, BCBSNM has a Care Coordination program that is part of case management. Case Management for medical health care uses a team of medical social workers and nurses (case managers), who help you make sure you are getting the help you need. They are there to help if you:

- have special health care needs
- need help with a lot of different appointments or getting community services not covered by the Medical Program
- are going to have a Transplant or other serious operation
- have a high-risk Pregnancy or have problems with your Pregnancy

Case managers work closely with your doctor to develop a care plan, which will help meet your personal medical needs. Please call Customer Service if you have any questions. (If you need case management for behavior health needs, call the BCBSNM Behavior Health Unit.) BCBSNM will work together with you and your doctor to make sure you get the care you need.

Care Coordination and Special Health Care Needs - Some Members need extra help with health care, may have long-term health problems and need more health care services than most Members, and/or may have physical or Mental Disorder problems that limit their ability to function. BCBSNM has programs to help Members with special health care needs, whether at home or in the Hospital. For example, you have special health care needs, the

authorization you receive for equipment and Medical Supplies may be valid for longer than usual so that your doctor does not have to order them so often for you.

If you believe your covered dependents have special health care needs, please call one of BCBSNM's care coordinators at the phone number below. The coordinator can provide you a list of resources to help you with special needs. BCBSNM also provides education for Members with special health care needs and their care givers. Programs include dealing with stress and information to help you and your family cope with a chronic illness.

If you have special needs, care coordination helps you by:

- assigning a person at BCBSNM who is responsible for coordinating your health care services
- making sure you have access to Providers who are experts for Members with special needs
- helping you schedule services for complex care, finding community resources such as the local food bank, housing, etc. and helping you get prepared in case of an Emergency
- helping with coordinating health services between doctors in the Preferred Provider network as well as Facilities in the Blue Distinction program for Transplants
- making sure case management is provided when needed

You can call BCBSNM care coordinator at: **1-800-325-8344** (select the **TRIAD** option)

IF YOUR PRIOR AUTHORIZATION REQUEST IS DENIED

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

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

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

LENGTH OF STAY/SERVICE REVIEW

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

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

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the *Appeal Procedure* section under this Benefit Booklet.

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

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of medical necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. BCBSNM will review the request to determine if it meets approved BCBSNM medical policy and site or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a specific service or category requires Prior Authorization, visit our website at www.bcbsnm.com/find-care/where-you-go-matters/utilization-management.com for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

a) No Guarantee of Payment

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

b) Request for Additional Information

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

Post-Service Medical Necessity Review

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

General Provisions Applicable to All Post-Service Medical Necessity Reviews

a No Guarantee of Payment

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

as of the date of service or the Member's benefits may have changed as of the date of service.

b Request for Additional Information

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

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this Group Health Care Plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on Covered Charges as determined by BCBSNM.

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 Medical Program, and is determined by BCBSNM's medical director (in consultation with your Provider) to meet all of the following definition:

Medically Necessary is defined as Health Care Services determined by a Provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, Mental Disorder or Chemical Dependency condition, illness, injury, or disease.

All services must be eligible for benefits as described in this section, not listed as an exclusion and/or meet all of the conditions of "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 at its sole discretion will determine Medical Necessity based on the criteria above.

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

In order to receive benefits:

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

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

AMBULANCE SERVICES

This Medical Program 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 Medical Program also covers Medically Necessary Ambulance transportation to a Hospital with appropriate Facilities, or from one Hospital to another.

Air Ambulance

Ground Ambulance is usually the approved method of transportation. This Medical Program covers Air Ambulance only when terrain, distance, or your physical condition requires the use of Air Ambulance services or for high-risk Maternity and newborn transport to Tertiary Care Facilities. To be covered, non-Emergency Air Ambulance services require **Prior Authorization** from BCBSNM.

Non-Emergency Air transport is covered only if transfer to another Facility is Medically Necessary to protect the life of the patient. It is recommended that you request Prior Authorization before securing the services of any air transportation Provider in order to verify that the service is Medically Necessary and will be covered.

BCBSNM determines on a case-by-case basis when Air Ambulance is covered. If BCBSNM determines that ground Ambulance services could have been used, benefits are limited to the cost of ground Ambulance services.

Exclusions

This Medical Program does **not** cover:

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

AUTISM SPECTRUM DISORDERS

This Plan covers the Habilitative and Rehabilitative Treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA) with no age restrictions or age limits for the Member. Providers must be credentialed to provide such therapy.

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

Services not approved through Prior Authorization by BCBSNM must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services will be denied. **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. These services also may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Policy. Please review the **Short-Term Rehabilitation: Occupational, Physical, Speech Therapy** section of this Policy.

Services are subject to usual Member cost-sharing features such as Deductible, Coinsurance, Copayments, and Out-of-Pocket Limits - based on place of treatment and type of service, and whether Prior Authorization was obtained from BCBSNM. 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 Medical Program, 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 Medical Program does **not** cover:

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

DENTAL-RELATED SERVICES AND ORAL SURGERY

The following services are the only Dental-Related Services and oral surgery procedures covered under this Medical Program. 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 must be sought **within 72 hours** of the accident and any services required after the initial treatment must be associated with the initial accident in order to be covered. (For treatment of TMJ or CMJ injuries, see "TMJ/CMJ Services.")

Facility Charges

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

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

Oral Surgery

This Medical Program covers the following oral surgical procedures only:

- Medically Necessary orthognathic surgery
- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands or ducts
- lingual frenectomy
- removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required

TMJ/CMJ Services

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

Exclusions

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

- surgeon's or Dentist's charges for non-Covered dental services
- hospitalization or general anesthesia for the patient's or Provider's convenience
- any service related to a dental procedure that is not Medically Necessary
- any service related to a dental procedure that is excluded under this Medical Program for reasons other than being dental-related, even if hospitalization and/or general anesthesia is Medically Necessary for the procedure being received (e.g., Cosmetic procedures, Experimental procedures, services received after coverage termination, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)

- removal of tori, exostoses, or impacted teeth
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, non-Covered Services, or preparing the mouth for dentures
- duplicate or "spare" Appliances
- personalized restorations, Cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an Accidental Injury and covered under "Dental and Facial Accidents" or "TMJ/CMJ Services"
- dentures, artificial devices and/or bone grafts for denture wear, including implants

DIABETIC SERVICES

Diabetic persons are entitled to the same benefits for Medically Necessary Covered Services as are other Members under this Medical Program. For special coverage details, such as for insulin, glucose monitors and educational services, refer to the applicable provisions as noted below. **Note:** This Medical Program 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 Medical Program 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 Medical Program covers the following supplies and equipment for diabetic Members and individuals with elevated glucose levels (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

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 Rider* within the limits of this Plan.

EMERGENCY CARE AND URGENT CARE

Emergency Care

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

This Medical Program 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 or in the case of a pregnant woman the health of the unborn child. (In addition, services must be received in an Emergency Room, Trauma Center, or Ambulance to qualify as an Emergency.) Examples of Emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning. Non-Emergency services provided in an emergency room for treatment of Mental Disorders or Chemical Dependency will be paid the same as Emergency Care services.

For Accidental Injury to the mouth, jaw, teeth, or TMJ, see "Dental-Related Services and Oral Surgery."

Emergency Room Services

Acute Emergency Care is available 24 hours per day, 7 days a week. If services are received in an Emergency Room or other Trauma Center, **the condition and treatment must meet the definition of Emergency Care in order to be covered**. Services received in an Emergency Room that do not meet the definition of Emergency Care may be reviewed for appropriateness and may be denied. If you disagree with the Claim Administrator's determination in processing your benefits as non-Emergency Care instead of Emergency Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review *Section 8: Claims Payments and Appeals* section of this Policy for specific information on your right to seek and obtain a full and fair review of your Clam.

To decide if you have an Emergency, you should ask yourself:

- Are you using reasonably good judgment?
- Do you have severe medical or behavioral condition (including severe pain)?
- Do you believe your health could be seriously harmed if you do not get health care right away?
- Do you believe a bodily function, body part, or organ can be damaged if you do not get health care right away?

If you answered "yes" to one or more of the above questions, you may have an Emergency. Here are some examples of emergencies:

- bad chest pain or other pain
- hard time breathing
- bleeding you cannot stop
- loss of consciousness (passing out) or a new or bad seizure
- poisoning or drug overdose
- severe burns
- serious injury from an accident or fall such as a broken bone
- gunshot or stab wound
- injured eye
- feeling of wanting to hurt yourself or others

What is NOT an Emergency? Do not go to an Emergency Room if you are not having a true Emergency. The Emergency Room should never be used because it seems easier for you or your family. You may have to wait to be seen for a very long time and the charges for Emergency Room services are very expensive - even if you have only a small problem. **Members who use an Emergency Room when it is not necessary will be responsible for paying Emergency Room charges.**

You should NOT go to an Emergency Room for conditions such as, but not limited to:

- sore throat
- earache

- runny nose or cold
- rash
- stomach ache

This is NOT a complete list of non-Emergency conditions. If you have one of the above illnesses or problems or any other condition that is not an Emergency, call your doctor first. If you can not reach your doctor, call BCBSNM's free 24/7 Nurseline. A nurse will help you decide what to do to get better on your own or where you should go to get the kind of care that you need. The nurse may tell you to go to your doctor or an Urgent Care Center. If your doctor's office is closed, BCBSNM nurses can also help you decide what you should do.

If you call your doctor and his/her office staff instruct you to go to an Emergency Room and you believe that your condition is not a true Emergency, you may wish to consult the BSBSNM free 24/7 Nurseline for confirmation. Do NOT go to an Emergency Room if you do not believe you have an Emergency. Non-Emergency services, or Ambulance services, will not be covered - even if your doctor's office staff instructed you to go to an Emergency Room.

You do not need BCBSNM authorization before seeking **Emergency Room or Emergency Ambulance** services from either Participating or a Nonparticipating Provider. **Nonparticipating Provider care received without a Prior Authorization in any other setting (e.g., Physician's office or Urgent Care Center) will not be covered.** (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.) Emergency Room and Ambulance services for a condition that meets the definition of "Emergency Care" will be covered within the limits of the Health Care Plan. Services for conditions that do *not* meet the definition of "Emergency Care" and have not obtained **Prior Authorization** will **not** be covered.

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

Emergency Admission Notification

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 Nonpreferred Provider is paid at the Nonpreferred Provider benefit level (Services received in an office or Urgent Care Facility are not considered Emergency Care for purposes of this provision.)

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

After a visit to the Emergency Room, you may need follow-up care. The health care you receive will either keep your health stable or improve or resolve your health problem, called post-stabilization care. This Medical Program covers post-stabilization care in a Hospital or other Facility. For all follow-up care (which is no longer considered Emergency Care) and for all other non-Emergency Care, you will receive the Nonpreferred Provider benefit for the Covered Services of a Nonpreferred Provider, even if a Preferred Provider is **not** available to perform the service.

Member Copayments

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

Urgent Care

This Medical Program 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).

If you need Urgent Care, you have the choice of taking any of the following steps to receive care:

- Call your doctor's office and tell them you need to see a doctor as soon as possible, but that there is no Emergency. If your doctor tells you to go to the Emergency Room because he or she cannot see you right away and you do not believe you have an Emergency, please call the free BCBSNM 24/7 Nurseline for advice.
- Ask your doctor to recommend another Provider if he/she is unable to see you within 24 hours.
- Visit the nearest Urgent Care Center in the Preferred Provider network.
- If there is not a Preferred Provider center nearby, go to the closest Urgent Care Center (services will be covered only at the Nonpreferred Provider level of benefits).
- If you are outside New Mexico and need Urgent Care, call a Customer Service Advocate to help or go to a local Urgent Care Center.

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

HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This Medical Program covers the cost of hearing aids, the assessment, testing, the fitting and dispensing fees for hearing aids and ear molds, up to a combined maximum of one hearing aid per hearing-impaired ear every three years. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period for the impaired ear begins 36 months after the first hearing aid-related service (e.g., assessment, fitting cost, ear mold, etc.) OR on the date the next hearing aid- related service for that ear, whichever length of time is greater.

HEARING AIDS/RELATED SERVICES FOR MEMBERS AGE 21 AND OVER

This Medical Program covers the cost of hearing aids, the assessment, testing, the fitting and dispensing fees for hearing aids and ear molds, up to a combined maximum amount of **$2,200** every 36 months. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period for the impaired ear begins 36 months after the first hearing aid-related service (e.g., assessment, fitting cost, ear mold, etc.) OR on the date the next hearing aid-related service for that ear, whichever length of time is greater.

HOME HEALTH CARE/HOME I.V. SERVICES

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

Conditions and Limitations of Coverage

If you are homebound (unable to receive medical care on an outpatient basis), this Medical Program covers Home Health Care Services and home I.V. services provided under the direction of a Physician. Nursing management must be through a Home Health Care Agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours.

Prior Authorization Required

Before you receive Home Health Care Services or home I.V. therapy, you, your Physician or Home Health Care Agency must obtain **Prior Authorization** from BCBSNM. **This Medical Program does not cover Home Health Care Services or home I.V. services without Prior Authorization.** See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Covered Services

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

- Skilled Nursing Care provided on an intermittent basis by a Registered Nurse or Licensed Practical Nurse

- Physical, Occupational, or Respiratory Therapy provided by licensed or certified Physical, Occupational, or Respiratory Therapists
- Speech Therapy provided by a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other Prescription Drugs ordinarily not available through a Retail Pharmacy if **Prior Authorization** is received from BCBSNM
- drugs, medicines, or laboratory services that would have been covered during an inpatient Admission
- enteral nutritional supplies (e.g., bags, tubing)
- Medical Supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions

This Medical Program does **not** cover:

- care provided primarily for you or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions.*)
- services provided by a nurse who ordinarily resides in your home or is a Member of your immediate family
- private duty nursing

HOSPICE CARE SERVICES

Conditions and Limitations

This Medical Program covers inpatient and home Hospice services for a Terminally Ill Member received during a Hospice Benefit Period when provided by a Hospice program and **Prior Authorization** is obtained from BCBSNM. If you need an extension of the Hospice Benefit Period, the Hospice agency must provide a new treatment plan and the attending Physician must recertify your condition to BCBSNM. (See definition of a Hospice Benefit Period in *Section 10* for more information.)

Prior Authorization Required

Before you receive Hospice Care, your attending Physician or the hospice agency must request **Prior Authorization** from BCBSNM. **Hospice care services are not covered without Prior Authorization.** See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Covered Services

This Medical Program covers the following services, subject to the conditions and limitations under the Hospice Care benefit:

- visits from Hospice Physicians
- Skilled Nursing Care by a Registered Nurse or Licensed Practical Nurse
- physical and Occupational Therapy by licensed or certified physical or Occupational Therapists
- Speech Therapy provided by an American Speech and Hearing Association certified therapist
- Medical Supplies (If supplies are *not* provided by the Hospice agency, see "Supplies, Equipment and Prosthetics.")
- drugs and medications for the Terminally Ill Patient
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience (Such

services must be recommended by a Physician to help the Member or his/her family deal with a specified medical condition.)

- services of a home health aide under the supervision of a Registered Nurse and in conjunction with Skilled Nursing Care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care period for up to a maximum of ten days each during the six-month Hospice Benefit Period (*Respite care* provides a brief break from total care-giving by the family.)
- bereavement counseling provided by a M.S.W. or M.A. for immediate family members if ordered and received under the Hospice program during a Hospice Benefit Period or within three months of the death of the Member covered under this Medical Program (a maximum of three counseling sessions will be covered.)

Exclusions

This Medical Program 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 Medical Program
- care or services received after the Members coverage terminates
- pastoral or spiritual counseling
- bereavement counseling not billed as part of overall Hospice service

HOSPITAL/OTHER FACILITY SERVICES

If applicable, see:
"Dental-Related Services and Oral Surgery"
"Emergency and Urgent Care"
"Hospice Care"
"Maternity/Reproductive Services and Newborn Care"
"Psychotherapy (Mental and Chemical Dependency)

For inpatient Physician medical visits, see "Physician Visits/Medical Care."

For physical rehabilitation and Skilled Nursing Facility services, see "Short-Term Rehabilitation: Occupational, Physical, Speech Therapy (Inpatient and Outpatient, Including Skilled Nursing Facility."

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

Blood Services

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

Inpatient Services

Prior Authorization Required

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

Covered Services

For acute inpatient medical or surgical care received during a covered Hospital Admission, this Medical Program 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 **Prior Authorization** for Medically Necessary private room charges to be covered. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Acute Medical/Surgical Services

For acute inpatient medical or surgical care received during a covered Hospital Admission, this Medical Program covers semi-private room or Special Care Unit (e.g., ICU, CCU) expenses and other Medically Necessary services provided by the Facility. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semi-private room rate, whether or not a semi-private room is available. BCBSNM must give Prior Authorization for Medically Necessary private room charges to be covered.)

Medical Detoxification

This Medical Program 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. Prior Authorization is required for all inpatient hospitalizations. See "Psychotherapy (Mental Disorder and Chemical Dependency)" for information about benefits for Chemical Dependency rehabilitation. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Christian Science Sanatorium

A Christian Science Sanatorium will be considered a Hospital if it is accredited by the Commission of Accreditation of Christian Science Nursing Organization/Facilities, Inc. and the Member is admitted for the active care of an illness or injury. This Medical Program does not cover spiritual refreshment and all other exclusions and provisions of this Benefit Booklet that apply to medical care apply equally to Christian Science services. Note: Christian Science practitioners and sanatoriums are not considered unsolicited and you will receive benefits based solely on whether or not the Provider in question has a Preferred Provider contract with the local BCBS plan.

Blue Distinction® and Blue Distinction Specialty Care Program

Blue Distinction® ("Blue Distinction") is a national designation awarded by Blue Cross and Blue Shield Plans to health care Providers. The Blue Distinction Specialty Care Program includes two levels of designation: Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+). The Blue Distinction Specialty Care Program focuses on BDC and BDC+ Providers that excel in providing safe, effective treatment for specialty care needs.

Blue Distinction Centers

The Blue Distinction designation uses nationally consistent criteria to designate high-performing Providers based on objective, evidence-based selection criteria. The Blue Distinction Specialty Care Program's purpose is to assist you in finding BDC and BDC+ Providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care.

Blue Distinction Centers provide care in the following specialty care areas:

- Cardiac Care
- Cellular Immunotherapy (CAR-T)
- Fertility Care*
- Substance Use Treatment and Recovery
- Gene Therapy
- Spine Surgery
- Bariatric Surgery
- Knee and Hip Replacement Surgery
- Maternity Care
- Transplants (Stem cell/bone marrow, solid organ (heart, liver, lung, kidney) and combination solid organ (heart/lung, liver/kidney, pancreas/kidney)

* BDC and BDC+ Fertility Care programs are currently supported by plans with Fertility Care programs at the professional level.

While you are not required to see Blue Distinction Centers when you need care for one of the conditions listed above, if you choose a Blue Distinction Center for cardiac care for a congenital heart defect or if you choose any In-Network Facility for a Transplant (and services obtained **Prior Authorization** by your BCBSNM case manager), you may be eligible for covered travel and lodging benefits through the Medical Program (for a fully description of this additional coverage, see Travel and Lodging later in this section).

Exclusions

This Medical Program does **not** cover:

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

Outpatient or Observation Services

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

INJECTIONS AND INJECTABLE DRUGS

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

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

Exclusions

This Medical Program does **not** cover:

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

LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see "Surgery and Related Services."

This Medical Program covers Diagnostic Services, including but not limited to, pre-Admission testing, that are related to an illness or Accidental Injury. Covered Services include:

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")

- infertility-related testing (See "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans, cardiac CT scans
- MRIs
- psychological or neuropsychological testing
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an Accidental Injury or an illness

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

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

Family Planning

Covered family planning services include:

- health education
- the following categories of FDA-approved contraceptive drugs, devices, and services, subject to change as FDA guidelines are modified: progestin-only contraceptives, combination contraceptives, Emergency contraceptives, extended-cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices (IUDs), injectables, transdermal contraceptives, and vaginal contraceptive devices
- pregnancy testing and counseling
- vasectomies in the doctor's office

For these following covered family planning services, no Coinsurance, Deductible, Copayment, or benefit maximums will apply when received from a Provider in the Preferred (In-Network) or Participating Provider network. When these services are received from an Out-of-Network Provider, the usual Out-of-Network Deductible, Coinsurance, and Out-of-Pocket will apply.

- over-the-counter female contraceptive devices with a written prescription by a Health Care Provider
- FDA-approved contraceptive drugs and devices from the following categories of FDA-approved contraceptive drugs, devices, and services, subject to change as FDA guidelines are modified: progestin-only contraceptives, combination contraceptives, Emergency contraceptives, extended-cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices (IUDs), injectables, transdermal contraceptives, and vaginal contraceptive devices. Covered FDA approved contraceptive drugs and devices are listed on the contraceptive drugs and devices list posted on the BCBSNM website (www.bcbsnm.com) or available by contacting Customer Service 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.

Infertility-Related Services

This Medical Program does **not** cover:

- male contraceptive devices, including over-the-counter contraceptive products such as condoms
- 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
- diagnostic testing to diagnose the cause of 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

Pregnancy-Related/Maternity Services

If you are pregnant, you should call BCBSNM before your Maternity due date, soon after your Pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery. If not notified, benefits for covered Facility services may be reduced by **$300**. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

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

Covered Services

Covered Pregnancy-Related Services include:

- Hospital or other Facility charges for room and board and ancillary services, including the use of labor, delivery, and recovery rooms (This Medical Program 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 Medical Program 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
- elective, spontaneous, or therapeutic termination of Pregnancy prior to full term

Newborn Care

If you do not have coverage for your newborn on the date of birth, **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 Medical Program, no additional Deductible for the newborn is required for the Facility's initial routine nursery care if the covered newborn is discharged on the same day as the mother.

Covered Services

Covered Services for initial Routine Newborn Care include:

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

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

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in **TRIAD** SPD 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 reduced by $300. The baby's services will be subject to a separate Deductible, Coinsurance and Out-of-Pocket limit.

PHYSICIAN VISITS/MEDICAL CARE

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

This Medical Program covers Medically Necessary care provided by a Physician or other Professional Provider for an illness or Accidental Injury. **Your choice of Provider can make a difference in the amount you pay.** (See *Section 3: How Your Plan Works.*)

Office Visits and Consultations

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

Allergy Care

This Medical Program 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.

Christian Science Practitioners

A Christian Science practitioner will be considered a Physician under this Medical Program if such practitioner is approved and listed in the current issue of The Christian Science Journal, the official organ of the First Church of Christ, Scientist; and is providing active treatment for a diagnosed illness or injury according to the healing practices of Christian Science. This Medical Program does not cover spiritual refreshment and all other exclusions and provisions of this Benefit Booklet that apply to medical care apply equally to Christian Science services. Note: Christian Science practitioners and sanatoriums are not considered unsolicited and you will receive benefits based solely on whether or not the Provider in question has a Preferred Provider contract with the local BCBS plan.

Breastfeeding Support and Services

This Medical Program covers counseling and support services rendered by a lactation consultant such as a Certified Nurse Practitioner, Certified Nurse Midwife or midwife, not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from a Provider in the Preferred or Participating Provider network (if your plan has Out-of-Network benefits for non-Emergency services, Out-of-Network services are subject to the usual Out-of-Network Deductible, Coinsurance, and Out-of-Pocket).

Genetic Inborn Errors of Metabolism

This Medical Program covers Medically Necessary expenses related to the diagnosis, monitoring and control of Genetic Inborn Errors of Metabolism as defined in *Section 10: Definitions.* Covered Services include medical assessment, including clinical services, biochemical analysis, Medical Supplies, corrective lenses for conditions related to the Genetic Inborn Error of Metabolism, nutritional management and **approved** Special Medical Foods. In order to be covered, services cannot be excluded under any other provision of this Benefit Booklet and are paid according to the provisions of the Medical Program that apply to that particular type of service (e.g., Special Medical Foods are covered under your medical assessments under "Physician Visits/Medical Care" and corrective lenses under "Supplies, Equipment and Prosthetics").

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

Injections and Injectable Drugs

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

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

Mental Disorder Evaluation Services

This Medical Program covers medication checks and intake evaluations for Mental Disorders, Alcohol, and Drug Abuse. See "Psychotherapy (Mental Disorder and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

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

- visits for a condition requiring **only** medical care, unless related to Hospice Care
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a Provider who is not the surgeon and who provides medical care **not** related to the surgery (For the surgeon's services, see "Surgery and Related Services" or "Transplant Services.")
- medical care requiring **two or more** Physicians at the same time because of multiple illnesses
- initial Routine Newborn Care for a newborn added to coverage within the time limits specified in **TRIAD** Health Benefit Plan Summary Description (See "Maternity/Reproductive Services and Newborn Care" for details and for extended stay benefits.)

Nutritional Counseling

This Medical Program covers services provided by a registered dietician in an individual session for Members with medical conditions that require a special diet. Such medical conditions include: diabetes mellitus, coronary artery disease, congestive heart failure, sever obstructive airway disease, gout, renal failure, phenylketoriua, or hyperlipidemias. Benefits for nutritional counseling are limited to three individual sessions during a Member's lifetime for each covered medical condition.

Weight Management Programs

This Medical Program covers weight loss or other weight management programs, dietary control or medical obesity treatment if dietary advice and exercise are provided by a Physician, nutritionist or dietician licensed by the appropriate agency. The Member must have a body mass index of 40 or more (BMI is calculated as the patient's weight in kilograms divided by the patient's height in meters quartered). See Surgery and Related Services for information about surgery for weight loss purposes. This Medical Program does not cover nonmedical services such as Weight Watchers, Jenny Craig Personal Weight Management, gym, fitness club or spa programs.

PREVENTIVE SERVICES

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

The services listed under this provision are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult). You and your Physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your Health Care Plan. Coverage for a recommended Preventive Service that is otherwise considered Medically Necessary for an individual will be provided regardless of an individual's sex assigned at birth, gender identity or gender that BCBSNM has recorded.

This Medical Program 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");
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.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

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 or contact Customer Service at the toll-free number on your BCBSNM Health Plan Identification Card.

Drugs (including both prescription and over the counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

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

The list below is subject to change. A current list is available to you and your Physician on the USPSTF website at: www.uspreventiveservicestaskforce.org/Page/Name/recommendations, or you can contact customer services at 1-800-432-0750. Examples of Covered Services include, but are not limited to:

- routine adult and pediatric immunizations, including COVID-19 vaccines
- routine digital rectal exam, routine prostate screening
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for Members ages 9 - 45 years old
- access to obstetrical and gynecological care
- osteoporosis services
- well-woman visits and follow-up treatment
- alpha-fetoprotein IV screening
- 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;
- well-child care, including well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder
- screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened
- 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
- contraceptive drugs and devices

Exclusions

This Medical Program 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 nonpreventive physical examination
- routine eye examinations; eye refractions; or any related service or supply for Members over the age of 18
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section (See "Hearing Aids/Related Services.")

PSYCHOTHERAPY (MENTAL DISORDER AND CHEMICAL DEPENDENCY)

Note: You do not receive a separate Mental Disorder/Chemical Dependency ID Card; use your BCBSNM ID Card to receive all medical/surgical and Mental Disorder/Chemical Dependency services covered under this Medical Program.

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 determined by a Provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or Mental Disorder condition, illness, injury, or disease.

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

Prior Authorization Requirements

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

In order to receive benefits:

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

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

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

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

Send Claims* to:

Claims, Behavioral Health Unit
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Services Requiring Prior Authorization

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

- Outpatient Psychological Testing
- Neuropsychological Testing
- Intensive Outpatient Program (IOP) Treatment
- Electroconvulsive Therapy (ECT)
- Repetitive Transcranial Magnetic Stimulation
- Applied Behavioral Analysis (ABA) Therapies

You or your Physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving non-Emergency services, **benefits for Covered Services may be denied** as explained in the *Utilization Management* section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your Provider have received Prior Authorization for any services you plan to receive. The BHU Call Center is open 24/7 to assist Members and Providers with Emergency Admission inquiries and to respond to crisis calls.

If you are admitted for a medical condition and later transferred to another unit in the same or different Facility for Drug Abuse rehabilitation (or vice versa), **both Admissions must receive Prior Authorization**.

Prior Authorization is **not** required for group, individual, or family therapy office visits to a Physician or other Professional Provider licensed to perform Covered Services under this Medical Program.

Covered Services/Providers

Covered Services include solution-focused evaluative and therapeutic Mental Disorder services (including individual and group psychotherapy) received in a Psychiatric Hospital, an IOP (Intensive Outpatient Program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed Psychologists, and Other Providers as defined in *Section 10: Definitions*. 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 Medical Program. A Residential Treatment Center is a Facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other Facilities that provide primarily a supportive environment and address long- term social needs, even if counseling is provided in such Facilities. Patients in Residential Treatment Centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with Mental Illness and/or Chemical Dependency disorders.

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

Exclusions

This Medical Program does **not** cover:

- inpatient care that has not obtained Prior Authorization
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home, or their staff Members; foster care; or behavior modification services

- maintenance therapy or care provided after you have reached your rehabilitative potential (See the "Long-Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)
- biofeedback, hypnotherapy, or behavior modification services
- religious or pastoral counseling
- Custodial Care (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- hospitalization or Admission to a Skilled Nursing Facility (SNF), nursing home, or other Facility for the primary purpose of providing Custodial Care Service, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an Inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. 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 Disorder 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 Disorder professional practice
- the cost of any damages to a Treatment Facility
- residential treatment in excess of the lifetime maximum benefits specified on the Summary of Benefits

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 (see "Hospital/Other Facility Services").

Acupuncture and Spinal Manipulation

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

Cardiac and Pulmonary Rehabilitation

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

Congenital Heart Disease

Services covered under the congenital heart disease care program include any service listed as covered in this Benefit Booklet (such as office visits, diagnostic testing, etc.), but specifically target the following services for Members with congenital health disease: congenital heart disease surgical interventions, interventional cardiac catheterizations, fetal echo cardiograms, and in-utero services and other **approved** fetal interventions.

Blue Distinction Center for specialty care - while you are not required to use a Blue Distinction Center for treatment of congenital heart disease, you may choose a Blue Distinction Center and services obtain Prior Authorization by your BCBSNM case manager, you may be eligible for travel and lodging benefits described under Travel and Lodging later in this section, which applied to this treatment coverage for up to five days before a covered treatment and for one year following the date of the initial cardiac treatment.

Consult with your Physician and/or with a BCBSNM care coordinator to determine which Facility is best for you. You may view the entire list of Blue Distinction Center and review the criteria used in selection Facilities for the designation at the Blue Cross and Blue Shield Association web site at www.bcbs.com.

Chemotherapy and Radiation Therapy

This Medical Program 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 re-occurrence, early detection, or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the Member enters and leaves a qualified Cancer Clinical Trial and must accept BCBSNM's Covered Charges as payment in full (this includes the Health Care Plan's payment plus your share of the Covered Charge).

The Routine Patient Care Costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved Prescription Drugs that are not paid for by the manufacturer, distributor, or supplier of the drug.

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

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

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

Dialysis

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

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

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

Covered Services

This Medical Program 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
- Speech Therapy for children when provided by a licensed Speech Therapist given to a child under the age of three whose speech is impaired due to one of the following conditions:
  - infantile autism,
  - developmental delay or cerebral palsy,
  - hearing impairment, or
  - major congenital anomalies that affect speech such as, but not limited to cleft lip and cleft palate.
- Inpatient physical rehabilitation and Skilled Nursing Facility services when **Prior Authorization** is obtained from BCBSNM

Benefit Limits

Benefits are limited, if applicable, as specified in the *Summary of Benefits.* Benefits for Autism Spectrum Disorder will not apply toward, and are not subject to, any Occupational Therapy, Physical Therapy or Speech Therapy visits. **Note:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This Medical Program covers Short-Term Rehabilitation only.

Conditions of Coverage

To be eligible for benefits, therapies must meet the following conditions:

- there is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy. This period may be extended upon recommendation of the referring Preferred Physician, in consultation with BCBSNM.
- improvement would not normally be expected to occur without intervention.

Exclusions

This Medical Program does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Medical Program does not cover services that exceed maximum benefit limits, if any.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay except as 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 or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing
- drug therapy that has not received Prior Authorization

SUPPLIES, EQUIPMENT AND PROSTHETICS

For contraceptive devices, see "Maternity/Reproductive Services and Newborn Care: Family Planning."

For supplies or equipment used during an inpatient or outpatient stay, see "Hospital/Other Facility Services." (Supplies or equipment that are dispensed by a Facility for use outside of the Facility are subject to the provisions of this "Supplies, Equipment and Prosthetics" section.)

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

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Breast Pumps

This plan covers the rental of hospital grade breast pumps (but not exceed the total cost) or purchase of a manual or electric breast pump, including breast pump supplies and breast milk storage supplies with a written prescription from a health care Provider, and are not subject to coinsurance, deductible, copayment or benefit maximums when received from an in-network Provider. If your plan has out-of-network benefits for non-emergency services, out-of-network services are subject to the usual out-of-network coinsurance, deductible, and out-of-pocket expense limit. Electric breast pumps are limited to 1 per Benefit Period.

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Durable Medical Equipment and Appliances

This Medical Program covers the following items**:**

- Orthopedic Appliances
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, Hospital beds, crutches, and other Medically Necessary Durable Medical Equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when needed to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to Genetic Inborn Errors of Metabolism, or prescribed by a Physician as the only treatment available for keratoconus. (Duplicate glasses/lenses are not covered. Replacement is covered only if a Physician or Optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers
- Enteral Nutrition Products, Special Medical Foods

This Medical Program 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 Medical Program 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 (six pair per Calendar Year)

Orthotics and Prosthetic Devices

This Medical Program 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 **three bras** per Calendar Year
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and is covered only when
- orthotics (e.g., collars, braces, molds) prescribed by an eligible Provider to protect, restore, or improve impaired body function
- medically necessary speech generating devices (Prior Authorization is required, regardless of total cost)

When alternative Prosthetic Devices are available, the allowance for a prosthesis will be based upon the most Cost-Effective item. See Section 4: Utilization Management for more information about Prior Authorization requirements.

Exclusions

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, over the counter heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, 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 bed boards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit
- dental Appliances (See “Dental-Related Services and Oral Surgery” for exceptions.)

- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic Members should refer to "Diabetic Supplies and Equipment" earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a Health Care Provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, hearing aid assessment, testing, fitting of hearing aids or ear molds, or related services or supplies for persons in excess of the maximum benefit described in this section (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services" below.)
- syringes or needles for self-administering drugs
- items that can be purchased over-the-counter, including but not limited to gauze, and bandages
- Female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Health Care Provider. (See "Maternity/Reproductive Services and Newborn Care: Family Planning" for devices requiring a prescription.)
- items not listed as covered
- costs for items received from a Nonpreferred Provider

SURGERY AND RELATED SERVICES

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

Surgeon's Services

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

Cochlear Implants

This Medical Program 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 Medical Program 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 Medical Program also covers cosmetic breast surgery when received **within 12 months** of a mastectomy for breast cancer (unless a later surgical procedure is approved as medically appropriate by BCBSNM). 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

Obesity Surgery

This Medical Program covers the surgical treatment of Morbid Obesity only when the Member meets medical criteria established by BCBSNM. Medical policies are posted on BCBSNM's website (http://www.medicalpolicy.hcsc.net/medicalpolicy/index?corpEntCd=NM1 and may change without notice. Check the website for the most current Medical Policy or call a Customer Service Advocate for assistance. *(Morbid obesity* means 45 kilograms or 100 percent over ideal body weight.)

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 Medical Program covers Reconstructive Surgery when required to correct a **functional** disorder caused by:

- an Accidental Injury
- a disease process or its treatment (For breast surgery following a mastectomy, see "Mastectomy Services," above.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

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

Exclusions

This Medical Program does **not** cover:

- Cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services")
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of Medically Necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous non-Covered procedure (such as a non-Covered Organ Transplant, or previous Cosmetic surgery)
- the insertion of artificial organs, or services related to Transplants not specifically listed as covered under "Transplant Services"
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby Physician actually assists

Anesthesia Services

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

Exclusions

This Medical Program 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 Medical Program does **not** cover:

- services of an assistant only because the Hospital or other Facility requires such services
- services performed by a resident, intern, or other salaried employee or person paid by the Hospital
- services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon

TRANSPLANT SERVICES

Prior Authorization, requested in writing, must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if Prior Authorization is not obtained from BCBSNM. If approved, a BCBSNM case manager will be assigned to you (the Transplant recipient candidate) and must later be contacted with the results of the evaluation.

If you are approved as a Transplant recipient candidate, you must ensure that **Prior Authorization** for the actual Transplant is also received. None of the benefits described here are available unless you have this Prior Authorization. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Facility Must Be in Transplant Network

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

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

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

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

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

Cost-Sharing Provisions

Covered Services related to the above Transplants are subject to the usual cost-sharing features and benefit limits of this Medical Program (e.g., Deductible, Coinsurance and Out-of-Pocket Limits; and annual Home Health Care maximums, if applicable).

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

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

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

Reminder: A Transplant received at a Facility that does **not** contract directly or indirectly with BCBSNM to provide Transplant services is **not** covered.

Blue Distinction Centers for Transplants

While you can select any In-Network Facility for your Transplant, the Blue Distinction Center for Transplants program can help you find the Transplant program that meets your needs. Blue Distinction Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for Transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert Physician and medical organization recommendations, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for Accreditation of Cellular Therapy (FACT), and is subject to periodical reevaluation as criteria continues to evolve.

Blue Distinction Centers for Transplants provide a range of services for Transplants including:

- heart or heart-lung;
- lung (deceased and living donor);
- liver (deceased and living donor, liver/small bowel;
- kidney or simultaneous pancreas-kidney (SPK);
- pancreas (PAK/PTA);
- bone marrow/peripheral stem cell (autologous and allogeneic, meaning either from yourself or from a compatible donor) with or without high-dosed Chemotherapy (**Not** all bone marrow Transplants are covered. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.)

Organ or tissue or multiple organ Transplant other than those listed above are **not** covered.

You may view the entire list of Blue Distinction Centers and review the criteria used in selecting Facilities for the designation at the Blue Cross and Blue Shield Association web site at https://www.bcbs.com/blue-distinction-center/facility.

Transplant Exclusions

This Medical Program does **not** cover:

- donor expenses after the donor has been discharged from the Transplant Facility
- Transplant-Related Services for a Transplant that did not receive **Prior Authorization** from BCBSNM (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.)
- any Transplant or organ-combination Transplant not listed as covered

- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM Medical Policy)
- nonhuman organ Transplants
- care for complications of non-Covered Transplants or follow-up care related to such Transplants
- services related to a Transplant performed in a Facility not contracted directly or indirectly with BCBSNM to provide the required Transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a Member of this Medical Program 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 Medical Program

TRAVEL AND LODGING EXPENSES

This Medical Program covers the following travel and lodging benefits, that have obtained Prior Authorization by the BCBSNM case manager, for patients receiving the following types of care:

- congenital heart disease treatment at a Blue Distinction Center for specialty care
- covered Transplant at an In-Network Preferred Provider Facility (excluding cornea Transplants which are covered as any other surgical procedure)
- cancer care at a Blue Distinction Center for specialty care

This coverage is available for up to five days before the patients initial treatment at the Facility selected and for one year following the date of the initial treatment, Transplant or retransplant. After one year, services are subject to usual Medical Program benefits and must be covered under other provisions of the standard Medical Program in order to be considered for benefit payment.

If a patient must temporarily relocate more than 50 miles outside his/her city of residence to receive treatment at an eligible Facility (as described above), this Medical Program covers travel of the patient and one companion traveling on the same day(s) to and/or from the Facility where the treatment will be received or the Transplant will be performed. Travel is covered if needed for the purposes of an evaluation, to undergo the procedure or other treatment, and/or received necessary post-discharge follow-up.

If a patient needs a covered treatment at an eligible Facility more than 50 miles from his/her home, a standard per diem benefit ($50) will be allocated for lodging expenses for the patient (while not confined) and another per diem benefit of $50 for one additional adult traveling with the patient (a combined per diem of $100). The patient is eligible for per diem allowance for outpatient therapy and pre-and post-operative care received on an outpatient basis. If the eligible patient is a covered child under the age of 18, this Medical Program covers travel and per diem expenses for two adults to accompany the child, but the daily per diem for lodging remains $100 for all three persons combined. Itemized receipts are **not** required, but you will need to indicate each day eligible for per diem reimbursement (for example, by sending a copy of your airline schedule showing your beginning and ending travel dates or hotel bill).

Travel expenses and standard per diem allowances for the patient and companion(s) are limited to a combined total lifetime maximum benefit of $10,000 per Member for each of the three following treatment/program types (regardless of how many Admissions or treatment the patent receives for each program type: congenital heart disease at a Blue Distinction Center for specialty care; and Transplants at an In-Network Preferred Provider Facility.

Your Care Coordinator may approve travel and $50 or $100 per diem lodging allowances based upon the number of persons traveling and the total number of days of temporary relocation, up to the maximum $10,000 lifetime benefit for each of the three programs.

The following travel expenses are covered when supported by receipts (or, in the case of mileage reimbursement, a reasonable estimate of distance travels using a standard map or Internet available programs that provide users with destination maps and mileage estimates: automobile mileage, reimbursed at the standard IRS medical purpose rate; taxi fares; economy/coach airfare (anything other than economy or coach is **not** covered); parking and/or tolls; trains, boat, or bus fares.

Travel Exclusions

This Medical Program does **not** cover:

- you receive treatment of congenital heart disease at a Facility other than a Blue Distinction Center.
- you choose to travel to receive care for which travel has not obtained Prior Authorization by the case manager

- automobile or rental or gasoline expenses.
- Ambulance to Facility (covered under standard Medical Program benefits and **not** reimbursed as travel expenses)
- 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 actual Transplant or the start of cancer care or treatment of congenital heart disease
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does **not** ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

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

This Medical Program does not cover any service or supply not specifically listed as a Covered Service in this Benefit Booklet. If a service is not covered, then all services performed in conjunction with it are not covered.

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

— Alternative Treatments

This Medical Program does not cover acupressure, aromatherapy, hypnotism, rolfing, naturopathy, holistic or homeopathic care, services of a naturalist, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health. This Medical Program does not cover chelation therapy except to treat heavy metal poisoning. Exception: This Medical Program does cover Medically Necessary services of a Christian Science Practitioner or Christian Science Sanatorium as explained in *Section 5: Covered Services*

— Before Effective Date of Coverage

This Medical Program 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 Medical Program does not cover services related to biofeedback.

— Blood Services

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

— Commission of a Felony

This Medical Program does not cover treatment of injuries sustained by a Member in the course of committing a felony. The Medical Program shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

— Complications of non-Covered Services

This Medical Program does not cover any services, treatments, or procedures required as the result of complications of a non-Covered Service, treatment, or procedure (e.g., due to a Cosmetic Surgery, Transplant, or experimental procedure).

— Convalescent Care or Rest Cures

This Medical Program 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 Medical Program does not cover** Cosmetic Surgery, Services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. **This Medical Program 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.**

Exception: Breast/nipple surgery performed as reconstructive procedures following a covered mastectomy may be covered. 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program will not cover** charges incurred after your Effective Date of Coverage under this Medical Program that are covered under the prior plan's extension of benefits provision.

— Duplicate Testing

This Medical Program does not cover duplicative diagnostic testing or overreads of laboratory, pathology, or radiology tests.

— Experimental, Investigational, or Unproven Services

This Medical Program does not cover any treatment, procedure, Facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined) or those considered Experimental, Investigational, or Unproven, unless for Acupuncture rendered by a licensed Doctor of Oriental Medicine or unless specifically listed as covered under "Autism Spectrum Disorders" or under "Cancer Clinical Trials" in *Section 5: Covered Services*. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is Experimental and will not be covered. To be considered Experimental, Investigational, or Unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the device, drug, or medicine is furnished.

- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

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

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating Facility, or the protocol(s) of another Facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating Facility or by another Facility studying substantially the same medical treatment, procedure, device, or drug. *Experimental or Investigational* does not mean cancer Chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

The service must be Medically Necessary and not excluded by any other 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 Medical Program 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.

— Foot Care

This Medical Program does not cover:

- routine foot care (trimming, cutting, or debridement of corns, calluses, toenails) unless required as part of Medically Necessary diabetic disease management or severe systemic disease,
- treatment of bunions (except surgical treatment such as capsular or bone surgery)
- hygienic and preventive maintenance foot care (e.g., cleaning and soaking of the feet, applying skin creams in order to maintain skin tone)
- other services that are performed when there is not a localize sickness, injury or symptom involving the foot
- treatment of flat feet
- treatment of subluxation of the foot

— Genetic Testing or Counseling

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

— Hair Loss Treatments

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

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

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

— Hypnotherapy

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

— Infertility Services/Artificial Conception

This Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program does not cover services of a Nonparticipating Provider if the Claim for such services is received by BCBSNM **more than 12 months** after the date of service. (Preferred Providers contracting directly with BCBSNM and Providers that have a "Participating" Provider agreement with BCBSNM will file Claims for you and must submit them within a specified period of time, usually 180 days.) If a Claim is returned for further information, resubmit it **within 45 days. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change. See *Section 8: Claims Payments and Appeals* for details.

— Learning Deficiencies/Behavioral Problems

This Medical Program does not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest Mental Disorder, retardation, or other disturbance. See "Autism Spectrum Disorders" in *Section 5: Covered Services* for details about mandated coverage for children with these diagnoses.

— Limited Services/Covered Charges

This Medical Program 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 Medical Program 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 Medical Program does not cover long-term therapy whether for physical or for mental conditions, even if Medically Necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies are considered long-term if measurable improvement is not possible **within two months** of beginning active therapy. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. (Chronic conditions include, but are not limited to, muscular dystrophy, Down's syndrome, and cerebral palsy.) **Note:** This exclusion does **not** apply to benefits for medication or medication management or to certain services for children with Autism Spectrum Disorders.

This Medical Program 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.

— Medical Tourism

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

— Medically Unnecessary Services

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

BCBSNM, in consultation with the Provider, determines whether a service or supply is Medically Necessary and whether it is covered. Because a Provider prescribes, orders, recommends, or approves a service or supply does *not* make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, determines Medical Necessity based on the criteria given in *Section 5: Covered Services*.)

— No Legal Payment Obligation

This Medical Program 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 Medical Program
- services for which you have received a professional or courtesy discount
- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member

- Physician charges exceeding the amount specified by Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

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

— Non-Covered Providers of Service

This Medical Program does not cover services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- Physician, other person, supplier, or Facility (including staff members) that are not specifically listed as covered in this Benefit Booklet, such as a:
  - health spa or health fitness center (whether or not services are provided by a licensed or registered Provider)
  - school infirmary
  - halfway house
  - massage therapist
  - private sanitarium
  - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or Group
  - homeopathic or naturopathic Provider

— Non-Covered Services

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

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

— Non-Emergency Services

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

— Nonmedical Expenses

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

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see "Physician Visits/Medical Care" and "Preventive Services" in *Section 5: Covered Services* for details.)
- autopsies
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; "get-acquainted" visits without physical assessment or medical care; provision of medical information to perform Admission review or other Prior Authorizations; filling out of Claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices that have not obtained Prior Authorization

- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a Hospice Admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the Members work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a Treatment Facility that are caused by the Member

— Nonpreferred Provider Services

This Medical Program does not cover Transplants when received from a Nonpreferred 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 (Prior Authorizations) 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 non-medical 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 Medical Program, except during an Emergency, if you do not first obtain Prior Authorization.

— Nutritional Supplements

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

— Post-Termination Services

This Medical Program does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) Prior Authorization for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered. (If you are an inpatient when coverage ends, covered benefits for the Admission end on the same date your coverage is terminated.)

— Prior Authorization Not Obtained When Required

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

— Private Duty Nursing Services

This Medical Program does not cover private duty nursing services.

— Psychotherapy (Mental Disorder and Chemical Dependency)

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

— Sexual Dysfunction Treatment

This Medical Program 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 Medical Program does not cover therapies and counseling programs other than the therapies listed as covered in this Benefit Booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this section, (see "Rehabilitation and Other Therapy" in *Section 5: Covered Services* for additional exclusions) **this Medical Program does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, weight-loss, and codependency programs
- smoking/tobacco use Cessation Counseling programs that do not meet the standards described under "Cessation Counseling" in *Section 10: Definitions*
- services of a massage therapist 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 Medical Program
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay and described in *Section 5* under "Autism Spectrum Disorders"
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher

— Thermography

This Medical Program 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 Medical Program does not cover** any other Transplants (or organ-combination Transplants) or services related to any other Transplants.

— Travel or Transportation

This Medical Program 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 Medical Program 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 Medical Program 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 Medical Program does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under "Supplies, Equipment and Prosthetics" in *Section 5: Covered Services.* **This Medical Program does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

— War-Related Conditions

This Medical Program does not cover any service required as the result of any act of war or related to an illness or Accidental Injury sustained during combat or active military service.

— Weight Management

This Medical Program does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment unless dietary advice and exercise are provided by a Physician, nutritionist, or dietitian licensed by the approved agency. Medical and surgical treatment of Morbid Obesity and covered weight management services are covered only when the Member has a body mass index (BMI = weight in kilograms divided by height in meters squared) of 40 or more. (Weight loss medications when Prior Authorization is obtained by BCBSNM, are covered only when Medically Necessary and for a BMI of 40 or more.)

— Work-Related Conditions

This Medical Program 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 Medical Program 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 Medical Program 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 Medical Program.)

If you are also covered by Medicare, special COB rules may apply. Contact a Customer Service Advocate for more information. If you are enrolled in federal continuation coverage, coverage ends at the beginning of the month when you become entitled to Medicare or when you become insured under any Other Valid Coverage.

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

The following rules determine which coverage pays first:

No COB Provision — If the Other Valid Coverage does not include a COB provision, that coverage pays first.

Medicare — If the Other Valid Coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first.

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

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

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

Child — For a child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the Other Valid Coverage does not follow this rule, the father's coverage pays first.

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

- *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- *Custodial/Noncustodial.* The Medical Program of the custodial parent pays first. The Medical Program of the spouse of the custodial parent pays second. The Medical Program 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 Medical Programs 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 Medical Programs do not agree on the order of benefits, the next rule applies.

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

Responsibility For Timely Notice

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

Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this Medical Program, 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 Medical Program, and with that payment BCBSNM will fully satisfy its liability under this provision.

Overpayments - Right of Recovery

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

REIMBURSEMENT

If you or one of your covered family members incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this Benefit Booklet, you agree:

- **TRIAD National Security, LLC** has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you and your legal representative as a result of that sickness or injury, in the amount of the total Covered Charges for Covered Services for which **TRIAD National Security, LLC** has provided benefits to you or your covered family members.
- **TRIAD National Security, LLC** is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits **TRIAD National Security, LLC** provided for that sickness or injury.

TRIAD National Security, LLC 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 **TRIAD National Security, LLC** has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM and/or **TRIAD National Security, LLC** may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 8: CLAIMS PAYMENTS AND APPEALS

IMPORTANT NOTE ABOUT FILING CLAIMS

This section addresses the procedures for filing Claims Payments and Appeals. The instructions in no way imply that filing a Claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this Benefit Booklet. All Claims submitted will be processed by BCBSNM according to the patient's eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all Prior Authorization requirements or benefits may be denied as explained in *Section 4: Utilization Management.* Covered Services are the same services listed as covered in *Section 5: Covered Services* and all services are subject to the limitations and exclusions listed throughout this booklet.

CLAIM FORMS AND PROOF OF LOSS

Written proof of loss must be furnished to BCBSNM in accordance with the Claim procedures specified in this *Section 8: Claims Payments and Appeals*. Proof may be submitted either electronically or on paper. Written notice of Claim must be given to BCBSNM within 365 days after the occurrence or start of the loss on which the Claim is based. If notice is not given in that time, the Claim will not be invalidated or denied if it is shown that written notice was given as soon as was reasonably possible. When BCBSNM receives a request for a Claim form or the notice of a Claim, BCBSNM will give the Member the Claim forms that we use for filing proof of loss. If the claimant does not receive these forms within 15 days after BCBSNM receives notice of Claim or the request for a Claim form, the claimant will be considered to meet the proof of loss requirements of this Medical Program 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 Medical Program, you need to file your Claim with the other coverage first. (See *Section 7: Coordination of Benefits (COB) and Reimbursement.*) After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile, or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the Claim sent to BCBSNM or to the local BCBS Plan, as instructed under "Where to Send Claim Forms" later in this section.

If the Other Valid Coverage pays benefits to you (or your family member) directly, give your Provider a copy of the payment explanation so that he/she can include it with the Claim sent to BCBSNM or to the local BCBS Plan. (If a Nonparticipating Provider does not file Claims for you, attach a copy of the payment explanation to the Claim that you send to BCBSNM or to the local BCBS Plan, as applicable.)

PARTICIPATING AND PREFERRED PROVIDERS

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

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

NONPARTICIPATING PROVIDERS

A Nonparticipating Provider is one that has neither a Preferred or a Participating Provider agreement. If your Nonparticipating Provider does not file a Claim for you, submit a separate Claim form for each family member as the services are received. Attach itemized bills and, if applicable, your Other Valid Coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the Claim form using the instructions on the form. (See special Claim filing instructions for out-of-country Claims under "Where to Send Claim Forms" later in this section.)

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

ITEMIZED BILLS

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

- Members identification number
- Members and Subscriber's name and address
- Members date of birth and relationship to the Subscriber
- name, address, National Provider Identification number (NPI), and tax ID or social security number of the Provider
- date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- accident or surgery date (when applicable)
- amount paid by you (if any) along with a receipt, cancelled check, or other proof of payment

Correctly itemized bills are necessary for your Claim to be processed. The only acceptable bills are those from Health Care Providers. Do **not** file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send them. The bills are not returned to you. All information on the Claim and itemized bills must be readable. If information is missing or is not readable, BCBSNM will return it to you or to the Provider.

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

WHERE TO SEND CLAIM FORMS

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

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

If a Nonparticipating Provider will not file a Claim for you, ask for an itemized bill and complete a Claim form the same way that you would for services received from any other Nonparticipating Provider. Mail the Claim forms and itemized bills to BCBSNM at the address below (or, if you prefer, you may send to the local Blue Cross Blue Shield Plan in the state where the services were received):

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

Mental Disorder/Chemical Dependency Claims

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

BCBSNM, BH Unit
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

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

For covered inpatient Hospital services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands), show your Plan ID Card issued by BCBSNM. BCBSNM participates in a Claim payment program with the Blue Cross and Blue Shield Association. If the Hospital has an agreement with the Association, the Hospital files the Claim for you to the appropriate Blue Cross Plan. Payment is made to the Hospital by that Plan, and then BCBSNM reimburses the other Plan.

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

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

The Blue Cross Blue Shield Global Core *International Claim Form* is to be used to submit institutional and professional Claims for benefits for covered Emergency services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. For filing instructions for other Claim types (e.g., dental, Prescription Drugs, etc.) contact 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 Core at the address below. Blue Cross Blue Shield Global Core will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the Claim. Once the Claim is finalized, the *Explanation of Benefits* will be mailed to the Subscriber and payment, if applicable, will be made to the Subscriber via wire transfer or check. Mail international Claims to:

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

CLAIMS PAYMENT PROVISIONS

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

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

If A Claim or Prior Authorization Is Denied

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

Covered Charge

Provider payments are based upon Preferred Provider and Participating Provider agreements and Covered Charges as determined by BCBSNM. For services received outside of New Mexico, Covered Charges may be based on the local Plan practice (e.g., for out-of-state Providers that contract with their local Blue Cross and Blue Shield Plan, the Covered Charge may be based upon the amount negotiated by the other Plan with its own Contracted Providers). You are responsible for paying Copayments, Deductibles, Coinsurance, and non-Covered expenses. For

Covered Services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

Participating and Preferred Providers

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

Nonparticipating Providers

If Covered Services are received from a Nonparticipating Provider, payments are usually made to the Subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the Provider and for paying any amounts greater than Covered Charges plus Copayments, Deductibles, Coinsurance, and non-Covered expenses.

Accident-Related Hospital Services

If services are administered as a result of an accident, a Hospital or Treatment Facility may place a lien upon a compromise, settlement, or judgment obtained by you when the Facility has not been paid its total billed charges from all other sources.

Assignment of Benefits

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

Medicaid

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

Medicare

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

Overpayments

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

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

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

b. Any future benefit payment made to any person or entity.

Pricing of Non-Contracted Provider Claims

The BCBSNM Covered Charge for some Covered Services received from Non-Contracted Providers is the lesser of the Provider's billed charges or the BCBSNM "Non-Contracting Allowable Amount." The BCBSNM Non-Contracting Allowable Amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). 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 Non-Contracting 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 Center 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 Non-Contracted Providers are excluded from this Non-Contracted 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 state's New Mexico Public Regulation Commission sets fares)
- covered Claims priced by a non-New Mexico BCBS Plan through BlueCard using local pricing methods

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

- Covered Services required during an Emergency and received in a Hospital, Trauma Center, or Ambulance
- for PPO Health Plans, services from Non-Contracted Providers that satisfy at least one of the three conditions below and, as a result, are eligible for the Preferred Provider benefit level of coverage
  - — Covered Services from Non-Contracted Providers within the United States that are classified as "Unsolicited" as explained earlier in *Section 3: How Your Plan Works* and as determined by the Members Host Plan while outside the Service Area of BCBSNM
  - — **Prior Authorization** of transition of care services received from Non-Contracted Providers
  - — Covered Services received from a Non-Contracted anesthesiologist, pathologist, or radiologist while you are a patient at a **Contracted** Facility receiving Covered Services or procedures that have been approved, if needed

BCBSNM will use essentially the same Claims processing rules and/or edits for Non-Contracted 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 the pricing method 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 Non-Contracted 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 non-Covered 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 **approved through Prior Authorization** and **not** eligible for 100 percent coverage of billed charges, such as during an Emergency) 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. Nonpreferred 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 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% = $5,850	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 Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you obtain Health Care Services outside of the BCBSNM Service Area, the Claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

Inter-Plan Arrangements link the BCBSNM Provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to Contracted Providers. When you receive care outside of the

BCBSNM Service Area, you will receive it from one of two types of Providers. Most Providers have a contractual agreement (i.e., are "Contracted Providers") with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Contracted Providers") don't contract with the Host Blue. BCBSNM explains below how BCBSNM pays both kinds of Providers.

You always have the choice to receive services from Contracted or Non-Contracted Providers in New Mexico or outside New Mexico, but the difference in the amount you pay may be substantial. When services are received by you outside the State of New Mexico from either Contracted or Non-Contracted Providers, the Host Blue will provide BCBSNM with a Covered Charge based on what it uses for its own local Members for services received from either Contracted or Non-Contracted Providers in the state where the Host Blue is located.

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

BLUECARD® PROGRAM

Services Received from Contracted Providers Outside of New Mexico

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

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

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

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

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

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

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

In some cases, BCBSNM may, but is not required to, in its sole discretion, negotiate a payment with a Non-Contracting Health Care Provider on an exception basis.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your liability calculation.

Services Received from a Non-Contracted Provider Outside of New Mexico

If services are provided by a Non-Contracted Provider, the Provider may, but is not required to, submit Claims on your behalf. A Non-Contracted Provider has not negotiated its payments/rates with either the Host Blue or BCBSNM. If the Non-Contracted Provider does not submit Claims on your behalf, you will be required to submit the Claims directly to the Host Blue. You will be subject to Balance Billing when you receive services from a Non-Contracted Provider. This amount may be significant. “Balance Billing" means that the Non-Contracted Provider may require you to pay any amount that the Provider bills that exceeds the sum of what BCBSNM pays toward the Covered Charge and your Member Share of the Covered Charge.

Member Liability Calculation

- **In General**

  Under Inter-Plan Arrangements, when services are received outside the State of New Mexico from a Non-Contracted 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 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. In addition to being responsible to pay your Member Share, you may be subject to Balance Billing by the Non-Contracted Provider who provided services to you. Before you receive services from a Non-Contracted Provider, you should ask for a written breakdown of all amounts that you will have to pay, including Member Share and Balance Billing amounts for the services you receive. Federal or state law, as applicable, will govern payments for Out-of- Network Emergency services.

- **Exceptions**

  In certain situations, BCBSNM may use other payment bases, to determine the amount BCBSNM will pay for services rendered by Non-Contracted Health Care Providers, such as (i) billed charges for Covered Services, (ii) the payment we would make if the Health Care Services had been obtained within our Service Area, (iii) a special negotiated payment, as permitted under the Inter-Plan 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 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 Non-Contracted Provider bills and the payment BCBSNM will make for the Covered Services as set forth in this paragraph.

Emergency Care Services:

If you experience an Emergency while traveling outside the BCBSNM Services Area, go to the nearest Emergency Medical Facility or Trauma Center.

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

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

SPECIAL CASES: VALUE-BASED PROGRAMS

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

BLUE CROSS BLUE SHIELD GLOBAL CORE

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

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

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

Emergency Care Services

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

MEMBER DATA SHARE

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

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

COMPLAINTS AND APPEALS; SUMMARY OF PROCEDURES

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

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

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

BCBSNM Contacts for Appeals

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

BCBSNM Appeals Unit

P.O. Box 27630

Albuquerque, NM 87125-9815

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

e- mail: See Website at

www.bcbsnm.com Fax: (505) 816-3837

TRIAD Administrative Errors and Eligibility Escalation Appeals Process

TRIAD is responsible for determining employee eligibility for coverage. If you have an administrative appeal about your eligibility, termination, contributions for coverage, or any other issue related to eligibility, please contact **TRIAD** or see the **TRIAD** SPD for details.

External Actions

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

External Review Board

If you are still not satisfied after having completed the appeal process administered by BCBSNM and described above, or if applicable, the eligibility and enrollment appeal process administered by **TRIAD** and described in the **TRIAD** SPD, you have the right to request a hearing in front of an External Review Board. If you choose to request a hearing, you will be sent details on the process.

SECTION 9: GENERAL PROVISIONS

ADVANCE DIRECTIVES

Advance directives are written documents (such as a Living Will, Health Care Treatment Directives, and Durable Power of Attorney) that designate a person with the responsibility for making your health care decisions if you are incapable of expressing your own wishes. They also describe the kind of treatment you do and do not want. Members over age 18 have the right to refuse or accept medical care or surgical treatments and to execute advance directives.

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 PCP or personal Physician to discuss these issues.

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any Hospital or other Facility within the BCBSNM network, nor that the services of a particular Hospital, Physician, or Other Provider will be available.

CATASTROPHIC EVENTS

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

CHANGES TO THE BENEFIT BOOKLET

No employee of BCBSNM may change this Benefit Booklet by giving incomplete or incorrect information, or by contradicting the terms of this Benefit Booklet. Any such situation will not prevent BCBSNM from administering this Benefit Booklet in strict accordance with its terms. See the inside back cover for further information.

DISCLAIMER OF LIABILITY

BCBSNM has no control over any diagnosis, treatment, care, or other service provided to you by any Facility or Professional Provider, whether Preferred or not. BCBSNM is not liable for any loss or injury caused by any Health Care Provider by reason of negligence or otherwise.

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

DISCLOSURE AND RELEASE OF INFORMATION

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

EXECUTION OF PAPERS

On behalf of yourself and your Eligible Family Members you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this Medical Program.

INDEPENDENT CONTRACTORS

The relationship between BCBSNM and its Network Providers is that of independent contractors; Physicians and Other Providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any Network Provider. BCBSNM will not be liable for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any Network Provider.

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

MEMBER RIGHTS

All Members have these rights:

- The right to available and accessible services, when Medically Necessary, as determined by your primary care or treating Physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or Emergency Care services, and for other health services as defined by your Benefit Booklet.
- The right to receive information about BCBSNM, our services, practitioners and Providers and Member rights and responsibility.
- The right to participate with practitioners in making decisions about your health care.
- The right to make recommendations regarding BCBSNM's Member rights and responsibility policy.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its Health Care Providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, Providers, and appeals procedures and other information about the company and the benefits provided.
- The right to receive from your Physician(s) or Provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to file a complaint or appeal with BCBSNM and to receive an answer to those complaints within a reasonable time.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for Prior Authorization and utilization review.
- The right to make recommendations regarding BCBSNM's Member rights and responsibilities policies.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review and the right to a secondary appeal.

MEMBER RESPONSIBILITIES

As a Member enrolled in a Managed Health Care Plan administered by BCBSNM, you have these responsibilities:

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

MEMBERSHIP RECORDS

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

REFUSAL TO FOLLOW RECOMMENDED TREATMENT

If you refuse treatment that has been recommended by a Participating Provider, the Provider may decide that your refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers

will try to render all necessary and appropriate professional services according to your wishes when they are consistent with the Provider's judgement. If you refuse to follow the recommended treatment or procedure, you are entitled to see another Provider of the same specialty for a second opinion. You can also pursue the appeal process.

RESEARCH FEES

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

SENDING NOTICES

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

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 **TRIAD National Security, LLC**.

SECTION 10: DEFINITIONS

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

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

Acupuncture — The use of needles inserted into the human body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition.

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

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

Admission — The period of time between the dates when a patient enters a Facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the Admission will be available only for those Covered Services received on and after your Effective Date of Coverage or those received before your termination date.)

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

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

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

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

Ambulatory Surgical Facility — An appropriately licensed Provider, with an organized staff of Physicians, that meets all of the following criteria:

- has permanent Facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient Basis; *and*
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the Facility; *and*
- does not provide inpatient accommodations; *and*
- is not a Facility used primarily as an office or clinic for the private practice of a Physician or Other Provider.

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

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

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

Autism Spectrum Disorder (ASD) — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, text revision, also known as *DSM-IV-TR,* published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rhett's disorder; and childhood integrative 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.

Benefit Program Application (BPA) — The application for coverage completed by the employer (or association representative).

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

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

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

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

Blue Distinction Centers (BDC) — A health care Provider, Hospital or medical facility recognized for their expertise in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

Blue Distinction Centers+ (BDC+) — A health care Provider, Hospital or medical facility recognized for their expertise and efficiency in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

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

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

Cardiac Rehabilitation — An individualized, supervised physical reconditioning exercise session lasting 4-12 weeks. Also includes education on nutrition and heart disease.

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

Certified Nurse Practitioner — A Registered Nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the Board of Nursing.

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

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

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

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

Child — See definition of "Eligible Family Member" in **TRIAD** Health Benefit Plan Summary Description.

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

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

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

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

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

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

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

Contracted Provider — A Provider that has a contract with BCBSNM or another BCBS Plan to bill BCBSNM (or other BCBS Plan) directly and to accept this health plan's payment (provided in accordance with the provisions of the contract) plus the Members share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services. Also see "Network Provider (In-Network Provider)," in this section.

Copayment — The fixed-dollar amount (or, in some cases, a percentage) that you must pay to a Health Care Provider upfront in order to receive a specific service or benefit covered under this Medical Program. 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 physical characteristics.

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

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

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

Covered Family Member, Covered Spouse, Covered Child — An eligible spouse, an eligible Domestic Partners, or Eligible Child (as defined in the **TRIAD** SPD) who has applied for and been granted coverage under the Subscriber's policy based on his/her family relationship to the Subscriber.

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

Creditable Coverage — Health care coverage through an employment-based Group Health Care Plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55

(military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe, or pueblo; the NM Medical Insurance Pool (NMMIP) Act, or similar state sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Custodial Care Services — Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care 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, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.), and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

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

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

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

Dentist, Oral Surgeon — A Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, Accidental Injuries and malformation of the teeth, jaws, and mouth.

Dependent — A person entitled to apply for coverage as specified in the **TRIAD** SPD. See "Eligible family member," below.

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

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

Effective Date of Coverage — 12:01 a.m. of the date on which a Members coverage under this Medical Program begins.

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

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

Eligible Family Members — See **TRIAD** SPD for description

Emergency, Emergency Care — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical Mental Disorder or Chemical Dependency condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. In addition, services must be received in an Emergency Room, Trauma Center, or Ambulance to qualify as an Emergency. Examples of Emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

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 Experimental or Investigational, treatment must meet all five of the following criteria:

- a technology must have final approval from the appropriate regulatory government bodies; however, approval by a governmental or regulatory agency will be taken into consideration by BCBSNM in assessing

Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative;

- the scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- the technology must improve the net health outcome;
- the technology must be as beneficial as any established alternatives; and
- the improvement must be attainable outside the Investigational settings.

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

FDA — The United States Food and Drug Administration.

Genetic Inborn Error of Metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume Special Medical Foods.

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

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

Group Health Care Plan — An employee Health benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the Medical Program 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 Medical Program).

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

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

Health Care Facility — An institution providing Health Care Services, including a Hospital or other licensed Inpatient Center, an Ambulatory Surgical or Treatment Center, a Skilled Nursing Facility, a Residential Treatment Center, a Home Health Care Agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

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

- brings Skilled Nursing Care and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for Home Health Care Agencies in New Mexico or in the state where the services are provided; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending Physician.

Home Health Care Services — Covered Services, as listed under "Home Health Care/Home I.V. Services" in *Section 5: Covered Services,* that are provided in the home according to a treatment plan by a certified Home Health

Care Agency under active Physician and nursing management. Registered Nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician.

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

Hospice Benefit Period — The period of time during which Hospice benefits are available. It begins on the date the attending Physician certifies that the Member is Terminally Ill and ends **six months** after the period began (or upon the Members death, if sooner). The Hospice Benefit Period must begin while the Member is covered for these benefits, and coverage must be maintained throughout the Hospice Benefit Period.

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

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

- diagnosis and treatment of illness, injury, deformity, abnormality or Pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution
- Treatment Facilities for Emergency Care and Surgical Services either within the institution or through a contractual arrangement with another licensed Hospital (These Contracted services must be documented by a well-defined plan and related to community needs.)

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

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

Initial Enrollment Eligibility Date — A Members Effective Date of Coverage or the first day of any Employee Probationary Period imposed on the Member by the employer, whichever is earlier. For a Late Applicant or for a person applying under a Special Enrollment provision, the Initial Enrollment Eligibility Date is his/her Effective Date of Coverage.

Inpatient Services — Care provided while you are confined as an inpatient in a Hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 5-12 hours of continuous Mental Disorder or Chemical Dependency care during any 24-hour period in a Treatment Facility).

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

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

Involuntary Loss of Coverage — As applied to Special Enrollment provisions, loss of other coverage due to legal separation, divorce, death, moving out of a Service Area, termination of employment, reduction in hours or termination of employer contributions (even if the affected Member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the

particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option and no substitute Plan was offered. If the Member is covered under a state or federal continuation policy due to prior employment, Involuntary Loss of Coverage includes exhaustion of the maximum continuation time period. Involuntary Loss of Coverage does not include a loss of coverage due to the failure of the individual or Member to pay premiums on a timely basis or termination of coverage for Good Cause.

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

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this Health Care Plan (e.g., 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.

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

Maternity/Pregnancy-Related — Any condition that is related to Pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of Pregnancy, such as ectopic Pregnancy, spontaneous abortion (miscarriage), elective abortion or C-section. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for more information.

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

Medical Detoxification — Treatment in an Acute Care Facility for withdrawal from the physiological effects of Alcohol or Drug Abuse. (Detoxification usually takes about three days in an Acute Care Facility.)

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

Medical Program — The component of the **TRIAD** Health Benefit Plan for Employees, ERISA Plan 501 or the **TRIAD** Health Benefit Plan for Retirees, ERISA Plan 502 that provides coverage and/or reimbursements, as explained in this Medical Program Benefit Program Material, for specified medical, surgical, Mental Disorder, Chemical Dependency, and prescription drug expenses. The Medical Program is a component of the overall plan.

Medical Supplies — Expendable items (except Prescription Drugs) ordered by a Physician or other Professional Provider, that are required for the treatment of an illness or Accidental Injury.

Medically Necessary, Medical Necessity — Health Care Services determined by a Provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, Mental Disorder or Chemical Dependency condition, illness, or disease.

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

Medicare-Participating Provider — A Health Care Provider or practitioner that accepts Medicare's approved amount as payment in full by accepting Medicare assignment. These Providers have been approved by the Department of Health and Human Services of the United States for receiving Medicare payments.

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

Mental Disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental Disorder does not include developmental disabilities, autism or Autism Spectrum Disorders, Drug or Alcohol Abuse, or learning disabilities.

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

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

Naprapathy — Therapy employing manipulation of connective tissue and dietary measures for facilitating the recuperative and regenerative processes of the body.

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.).

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

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

Nonparticipating Provider — See the definition of "Provider."

Nonpreferred Provider — See the definition of "Provider."

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

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

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

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

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

OSI — The Office of Superintendent of Insurance.

Other Valid Coverage — All other Group and individual (or direct-pay) insurance policies or Health Care Benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services will be considered Other Valid Coverage for purposes of coordinating benefits under this Medical Program.

Other Providers — Clinical Psychologists and the following masters-degreed psychotherapists (an independently licensed Professional Provider with either an M.A. or M.S. degree in psychology or counseling): Licensed Independent Social Workers (L.I.S.W.); Licensed Professional Clinical Mental Health Counselors (L.P.C.C.); masters-level Registered Nurse Certified in Psychiatric Counseling (R.N.C.S.); Licensed Marriage and Family Therapist (L.M.F.T.). For Chemical Dependency services, a Provider also includes a Licensed Alcohol and Drug Abuse Counselor (L.A.D.A.C.).

Out-of-Pocket Limit — The maximum amount of Deductible, Coinsurance, and/or Copayments that you pay for most Covered Services in a Calendar Year. After an Out-of-Pocket Limit is reached, this Medical Program pays **100 percent** of most of your Preferred or Nonpreferred Provider 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 Surgery — Any Surgical Services that is performed in an Ambulatory Surgical Facility or the outpatient department of a Hospital, but **not** including a procedure performed in an office or clinic. Outpatient Surgery includes any procedure that requires the use of an Ambulatory Surgical Facility or an outpatient Hospital operating or recovery room.

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

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

Physician — A Doctor of Medicine (M.D.) or Osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

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

Plan — The **TRIAD** Health Benefit Plan for Employees, ERISA Plan 501 or the **TRIAD** Health Benefit Plan for Retirees, ERISA Plan 502. This Medical Program is a component of the overall Plan. **TRIAD, LLC** is the Plan Administrator and the Plan Sponsor of the Plan and of this Medical Program component of the Plan.

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

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

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

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

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

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

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

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

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

Prosthetics or Prosthetic Device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed Hospital or other licensed Facility, Physician, or other Health Care Professional authorized to furnish Health Care Services within the scope of their license.

A Provider may belong to one or more networks, but if you want to visit a Network Provider, you must choose the Provider from the *appropriate* network:

> **PPP (Primary Preferred Provider):** A Preferred Provider in one of the following medical specialties: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; Oriental Medicine; or Pediatrics. PPPs do **not** include Physicians specializing in any other fields such as Obstetrics, Geriatrics, Pediatric Surgery or Pediatric Allergy.
>
> **Preferred Provider:** A Provider who has Contracted with BCBSNM as a Preferred Provider but does not practice one of the Primary Preferred Provider medical specialties.
>
> **Nonpreferred Provider:** Providers that have not Contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These Providers may have "Participating-only" Provider agreements, but are not considered Preferred Providers and are not eligible for Preferred Provider coverage under your health plan - unless listed as an exception under "Benefit Level Exceptions."
>
> **PPO Specialist:** A Practitioner of the Healing Arts who is in the Preferred Provider Network - but does not belong to one of the specialties defined above as being for a "Primary Preferred Provider" (or "PPP"). A specialist does not include Hospitals or other Treatment Facilities, Urgent Care Facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary Health Care Providers.
>
> **Network Provider** agrees to provide Health Care Services to Members with an expectation of receiving payment directly or indirectly from BCBSNM (or other entity with whom the Provider has Contracted). A Network Provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this Medical

Program's payment (provided in accordance with the provisions of the contract) plus the Members share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services. 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 Prior Authorization 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.

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

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

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

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

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

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

Rehabilitation Hospital — An appropriately licensed Facility that provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of Physical, Occupational, Speech, and Respiratory Therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Rehabilitative Service — Including, but not limited to Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Physician that must be limited to therapy which is expected to result in

significant improvement in the conditions for which it is rendered, "Rehabilitative Services" must be expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition.

Residential Treatment Center — A Facility 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.

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

Routine Newborn Care — Care of a child immediately following his/her birth that includes:

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

Routine Patient Care Cost — The cost for all items and services consistent with the coverage provided under this Medical Program 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;
- items and services that are not provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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:

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

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

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

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

Skilled Nursing Facility — A Facility or part of a Facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-Participating Facility; *and*
- is primarily engaged in providing Skilled Nursing Care to inpatients under the supervision of a duly licensed Physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a Registered Nurse; *and*
- does **not** include any Facility that is primarily a rest home, a Facility for the care of the aged, or for treatment of tuberculosis or for intermediate Custodial or educational care.

Sound Natural Teeth — Teeth that are whole, without impairment, without periodontal or other conditions and not in need of treatment for any reason other than Accidental Injury. Teeth with crowns or restorations (even if required due to a previous injury) are **not** Sound Natural Teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. (Your Provider must submit x-rays taken *before* the dental or surgical procedure in order for BCBSNM to determine whether the tooth was "sound.")

Special Care Unit — A designated unit that has concentrated Facilities, equipment and supportive services to provide an intensive level of care for critically ill patients. Examples of Special Care Units are Intensive Care Unit (ICU), Cardiac Care Unit (CCU), sub intensive care unit, and isolation room.

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

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

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

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

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

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

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

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

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

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

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

Transplant-Related Services — Any hospitalizations and medical or Surgical Services related to a covered Transplant or retransplant and any subsequent hospitalizations and medical or Surgical Services related to a covered Transplant or retransplant, and received within one year of the Transplant or retransplant.

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

Well-Child Care — Periodic health and development assessments and screenings, immunizations, and physical exams provided to children who have no symptoms of current illness as recommended by the American Academy of Pediatrics and the U.S, Preventive Services Task Force (USPSTF).

APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under this Group Health Care Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger Group employers. COBRA continuation coverage may be available to you and to other Members of your family who are covered under the Health Care Plan when you would otherwise lose your Group health coverage. Contact 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 Medical Program and under federal law, contact the Plan Administrator or see **TRIAD** Health Benefit Plan Summary Description.

The Plan Administrator of the Medical Program 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 Medical Program, 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program as an "Eligible Child".

If the Medical Program 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 Medical Program, 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 Medical Program.

The Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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.

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

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

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

GENERAL INQUIRIES AND COMPLAINTS

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

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

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

INITIAL INTERNAL REVIEW OF CLAIMS/PRIOR AUTHORIZATION REQUESTS

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

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

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

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

- ***Urgent Care Clinical Claim*** - Any pre-service Claim that requires Prior Authorization, as described in the Benefit Booklet, for a benefit determination for medical care or treatment for which the application of regular notification time periods could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of the Physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment
- ***Post-service Claim*** - A notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

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

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

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

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

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

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

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

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

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

Concurrent Care

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

MANNER AND CONTENT OF CLAIM/PRIOR AUTHORIZATION DENIAL NOTICES

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

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

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

- a description of BCBSNM's internal review/appeals and external review procedures and time limits (and how to initiate a review/appeal or external review) including a statement of your right, if any, to pursue any state and, if applicable, federal legal remedies, including bringing a civil action under Section 502(a) of ERISA, following a final denial on internal review/appeal;
- in certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- the right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claim for benefits;
- in the case of a denial of an Urgent Care Clinical Claim, a description of the expedited internal review procedure applicable to such Claims (an Urgent Care Claim decision may be provided orally, so long as written notice is furnished to you within three days of oral notification);
- contact information for applicable office of health insurance consumer assistance or ombudsman.

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

INTERNAL APPEAL PROCEDURES

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

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

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

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

Expedited Clinical Appeals

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

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

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

How to Appeal an Adverse Benefit Determination

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

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

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

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

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926

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

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

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

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926
FAX: (505) 816-3837

Time-frame for Completion of Internal Appeal

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

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

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

Manner and Content of Notification of Internal Appeal Decision

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

- subject to privacy laws and other restrictions, if any, the identification of the Claim, the date of service, Health Care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for the determination;
- the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
- any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- a description of the standard that was used in denying the Claim and a discussion of the decision;
- a description of BCBSNM's internal review procedures and time limits including your right to pursue, if applicable federal legal remedies including bringing a civil action under 502(a) of ERISA following a final Adverse Determination on internal appeal and the timeframe within which such action must be filed;
- in certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- contact information for applicable office of health insurance consumer assistance or ombudsman.

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

INDEPENDENT EXTERNAL REVIEW

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

1. Request for external review. Within four months after the date of receipt of a notice of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* from BCBSNM, you or your authorized representative must file your request for standard external review.

2. Preliminary review. Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the Medical Program at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Medical Program at the time the health care item or service was provided;
- The *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* does not relate to your failure to meet the requirements for eligibility under the terms of the Medical Program (e.g., worker classification or similar determination);
- You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the "Exhaustion" section below for additional information about the exhaustion of the internal appeal process; and
- You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within one business day after BCBSNM completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your Claim is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

External review is available for *Adverse benefit Determinations* and *Final Adverse Benefit Determinations* that involve rescission and determination that involve medical judgment including, but not limited to, those based on requirements for Medical Necessity, appropriateness, health care setting, Investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program or a determination of compliance with the non-quantitative treatment limitation provisions of the Mental Health parity.

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, BCBSNM or your employer will assign the matter to an unbiased and independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Accordingly, BCBSNM must contract with at least three IROs for assignments under the Medical Program and rotate Claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the Medical Program.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must

consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during BCBSNM's internal Claims Payments and Appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    - — Your medical records;
    - — The attending Health Care Professional's recommendation;
    - — Reports from appropriate Health Care Professionals and other documents submitted by BCBSNM, you, or your treating Provider;
    - — The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the Medical Program, unless the terms are inconsistent with applicable law;
    - — Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
    - — Any applicable clinical review criteria developed and used by BCBSNM, unless the criteria are inconsistent with the terms of the Medical Program or with applicable law; and
    - — The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and you or your authorized representative.
- The notice of final external review decision will contain:
    - — A general description of the reason for the request for external review, including information sufficient to identify the Claim;
    - — The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - — References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    - — A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

— A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either BCBSNM and you or your authorized representative;

— A statement that judicial review may be available to you or your authorized representative; and

— Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- After a final external review decision, the IRO must maintain records of all Claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, BCBSNM immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim.

Expedited External Review

1. Request for expedited external review. BCBSNM must allow you or your authorized representative to make a request for an expedited external review with BCBSNM at the time you receive:

- An *Adverse Benefit Determination* if the *Adverse Benefit Determination* involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A *Final Internal Adverse Benefit Determination*, if the claimant has a medical condition where the time-frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the *Final Internal Adverse Benefit Determination* concerns an Admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but have not been discharged from a Facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the "Standard External Review" section above. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the "Standard External Review" section above. BCBSNM must provide or transmit all necessary documents and information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the Claim de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal Claims Payments and Appeals process.

4. Notice of final external review decision. The IRO must provide notice of the final external review decision, in accordance with the requirements set forth in the "Standard External Review" section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSNM and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you have the right to request external review simultaneously with the request for expedited internal review. The IRO will

determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal Claims Payments and Appeals process. If you have been deemed to have exhausted the internal review process due to BCBSNM's failure to comply with the internal Claims Payments and Appeals process, you may also have the right to pursue any available remedies under 502(a) of ERISA or under state law.

The internal review process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Claim Administrator demonstrates that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Claims Administrator.

External review may not be requested for an Adverse Benefit Determination involving a Claim for benefits for a Health Care Service that you have already received until the internal review process has been exhausted.

OTHER EXTERNAL ACTIONS

If you are still not satisfied after having completed BCBSNM's or, for eligibility and employee contribution issues, your employer's complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action at law or in equity may be taken or arbitration demand made earlier than 60 days after the Claims Administrator has received the Claim for benefits or Prior Authorization request, or later than three years after the date that the Claim for benefits should have been filed with the Claims Administrator.

Additional Resources — If you need additional assistance, you may call the U.S. Department of Labor's Employee Benefits Security Administration (EBSA):

Call toll-free at (866) 444-EBSA (3272) or visit the EBSA Web site at www.askebsa.dol.gov

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, NW
Washington, DC 20210

RETALIATORY ACTION

BCBSNM and your employer shall not take any retaliatory action against you for making a complaint, filing an appeal, or requesting external review under this health plan.

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

Acceptance of coverage under this Benefit Booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this Benefit Booklet.

The legal agreement between **TRIAD National Security, LLC** and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this Benefit Booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the Subscriber and his/her dependents;
- the Members Identification Cards; and
- the *Summary of Benefits*

In addition, your employer (or association) has important documents that are part of the legal agreement:

- the Benefit Program Application from the employer; and
- the Administrative Services Agreement between BCBSNM and **TRIAD National Security, LLC**.

The above documents constitute the entire legal agreement between BCBSNM and **TRIAD National Security, LLC**. No agent or employee of BCBSNM has authority to change this Benefit Booklet or waive any of its provisions. You will be notified of any changes to this Benefit Booklet at least 30 days before the changes become effective.

TRIAD National Security, LLC reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This booklet is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative Claims payments only and does not assume any financial risk or obligation with respect to Claims, except as may be specified in the Administrative Service Agreement.

AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or New Mexico law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if

You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to this No Surprises Act Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any

bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of New Mexico (BCBSNM) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSNM for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or

service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. <u>Federal No Surprises Act Surprise Billing Protections</u>

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider deductible and/or Out-of-Pocket Limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

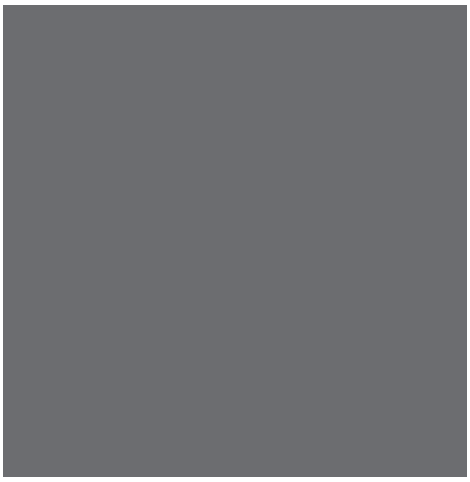
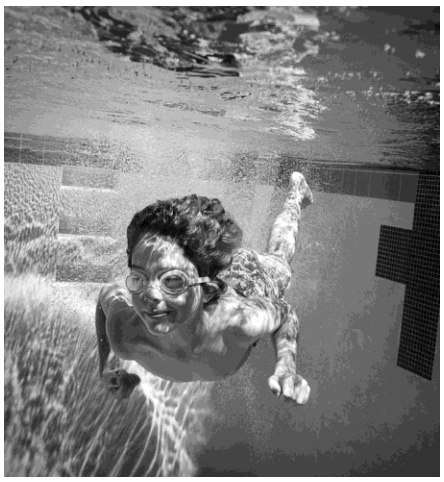
If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

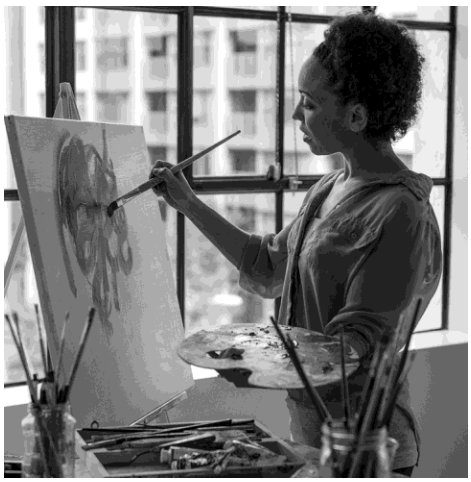
When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance

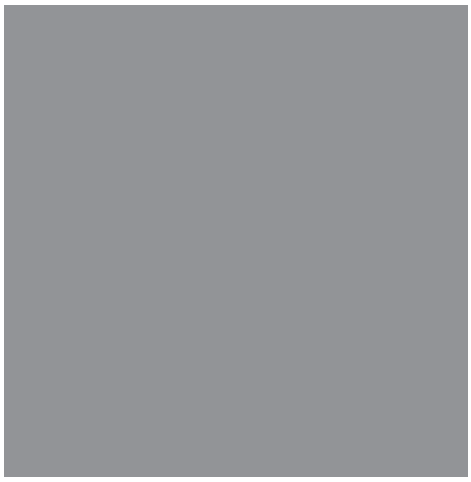
billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.



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